

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09920

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09925

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Pr. Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> | | c. LENGTH OF STAY IN lb <u>DOA</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u> | | d. STREET ADDRESS <u>Hillside Md</u> | |
| 3. NAME OF DECEASED (Type or print) <u>GEORGE ADDISON</u> | | 4. DATE OF DEATH <u>July 14 1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 2 1908</u> |
| 9. AGE (In years lost birth day) <u>58</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>16</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Sam Addison</u> | | 14. MOTHER'S MAIDEN NAME <u>Carry Harrison</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>1508 58 ave Hillside Md</u> | |
| 17. INFORMANT <u>Katue Addison</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ed. Haulston</u> DUE TO <u>1548</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Rectum</u> DUE TO <u>1 yr</u> (c) <u></u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-12-67 | |
| EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 5318 annapolis rd | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Blacksburg Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/17/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u> | |
| 24. FUNERAL DIRECTOR <u>John T. Stewart</u> ADDRESS <u>Stewart Funeral Home-4001 Benning Road,</u> | | 25a. REC'D BY REGISTRAR <u>N.E. JUL 17 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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|---|--|---|--|---|--|--|--|
| <p>1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND</p> | | | | <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's.</p> | | | |
| <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leland</p> | | <p>c. LENGTH OF STAY IN 1b Leland</p> | | <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville</p> | | | |
| <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital</p> | | | | <p>d. STREET ADDRESS 3907- Calverton Drive</p> | | <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | |
| <p>3. NAME OF DECEASED (Type or print) WILLIAM E. ADLUNG First Middle Last</p> | | | | <p>4. DATE OF DEATH July 25th 1967 Month Day Year</p> | | | |
| <p>5. SEX Male</p> | | <p>6. COLOR OR RACE White</p> | | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | | <p>8. DATE OF BIRTH Feb. 22nd. 1891</p> | |
| <p>9. AGE (In years last birthday) 76 yrs.</p> | | <p>IF UNDER 1 YEAR Months Days Hours Min.</p> | | <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired</p> | | | |
| <p>10b. KIND OF BUSINESS OR INDUSTRY Auto Dealer</p> | | <p>11. BIRTHPLACE (County & State, or foreign country) Washington, DC.</p> | | <p>12. CITIZEN OF WHAT COUNTRY? USA</p> | | | |
| <p>13. FATHER'S NAME John Adlung</p> | | | | <p>14. MOTHER'S MAIDEN NAME Annie Gunser</p> | | | |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</p> | | <p>16. SOCIAL SECURITY NO.</p> | | <p>17. INFORMANT Wife Address Minnie E. Adlung-Same as Item #2</p> | | <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) acute coronary thromboses DUE TO (c) arteriosclerotic heart disease</p> | |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> | | | | | | <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> | | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p> | | | | | |
| <p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p> | | <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> | | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> | | <p>20f. (City or town) (County) (State)</p> | |
| <p>21. I certify that (I) (this hospital) attended the deceased from July 15, 1966 to July 25, 1967, that (I) (we) last saw the deceased alive on June 28, 1967, and that death occurred at 4 P. M, from the causes and on the date stated above.</p> | | | | | | | |
| <p>22a. SIGNATURE Don B. Cameron</p> | | | | <p>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p> | | <p>22b. DATE SIGNED 7-25-67</p> | |
| <p>22c. PHYSICIAN'S NAME (Type) DON B. CAMERON</p> | | | | <p>22d. ADDRESS 3503 PERRY STREET</p> | | | |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p> | | <p>23b. DATE THEREOF July 28-67</p> | | <p>23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery</p> | | <p>23d. LOCATION (City, town or county) (State) Suitland, Maryland MD</p> | |
| <p>24. FUNERAL DIRECTOR Simmons Bros. ADDRESS 1661- Gd. Hope Road SE. Wash., DC</p> | | | | <p>25a. REC'D BY REGISTRAR JUL 31 1967 25b. REGISTRAR'S SIGNATURE James J. Jones</p> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09922

CERTIFICATE OF DEATH

09927

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b 2 hours | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | 161 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 6204 Kilmer Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Ellis Middle R. Last Allen | | | | 4. DATE OF DEATH Month July Day 13 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 20, 1910 | | 9. AGE (In years last birthday) 56 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant supervisor | | 10b. KIND OF BUSINESS OR INDUSTRY air products | | 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James Henry Allen | | | | 14. MOTHER'S MAIDEN NAME Estelle Swift | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Estelle H Allen Address Cheverly, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute posterior wall myocardial infarction DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/17 , 19 65 , to 7/13 , 19 67 , that (I) (we) last saw the deceased alive on 7/13 , 19 67 , and that death occurred at 5:02 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Dr. Frederick H. Wilhelm | | 22c. PHYSICIAN'S NAME (Type) Dr. Frederick H. Wilhelm | | 22d. ADDRESS 6319 Landover Rd., Cheverly, Md. | | 22b. DATE SIGNED 7/13/67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 15, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DATE JUL 17 1967 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

INVESTIGATION OF CRIME

Prince George's

Marshall

Prince George's

County

Prince

County

PRINCE GEORGE'S

PRINCE GEORGE'S

July 1

Allen

Allen

Nov. 21, 1914

Nov. 21, 1914

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

29923

09928

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|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Id</u> b. COUNTY <u>Pr George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier Md</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3116 Varnum</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Daisy Leona Almond</u> | | 4. DATE OF DEATH <u>29 July 1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1 June 1884</u> |
| 9. AGE (in years last birthday) <u>83</u> | | 10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Marcelus Langley</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Ann Thompson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>220-44-8998</u> | |
| 17. INFORMANT <u>Ennis Almond</u> | | Address <u>3114 Varnum</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest of anginal syndrome</u> DUE TO (b) <u>Pernicious anemia following</u> DUE TO (c) <u>carcinoma stomach</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u> <u>1 year</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>30 July 1967</u> to <u>29 July 1967</u> , that (I) (we) last saw the deceased alive on <u>29 July 1967</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Thomas E. Mattingly M.D.</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Thomas E. Mattingly, M.D.</u> | | 22d. ADDRESS <u>2206 R.I. Ave N.E. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/3/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u> | | 23d. LOCATION (City, town or county) (State) <u>Ar Va</u> | |
| 24. FUNERAL DIRECTOR <u>H. J. Hamilton & Son</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>AUG 1 1967</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items #2c & d Film #G391 7/26/67 ph

CERTIFICATE OF DEATH

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Reg. Dist. No.

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|---|--|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | | | c. LENGTH OF STAY IN 1b 3 mos. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5311 Hamilton St. | | | | d. STREET ADDRESS 5311 Hamilton St. Apt. #4 | | | |
| 3. NAME OF DECEASED (Type or print) First Catherine Middle Louise Last Amos | | | | 4. DATE OF DEATH Month July Day 17 Year 19 67 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 7, 1911 | |
| 9. AGE (In years last birthday) 56 yrs. | | 10. UNDER 1 YEAR Months 2 Days 4 Hours 17 Min. | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Retail Store | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | |
| 13. FATHER'S NAME William L. Warner | | | | 14. MOTHER'S MAIDEN NAME Mary M. Imhoff | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 579 01 9097 | | | |
| 17. INFORMANT Delores Parezo | | | | Address 5311 Hamilton St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Gen 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma 7 heart DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| 20f. (City or town) | | | 20g. (County) | | 20h. (State) | | |
| 21. I certify that I attended the deceased from May 15 , 19 66 , to 7/17 , 19 67 , that I last saw the deceased alive on 7/15 , 19 67 , and that death occurred at 2:20 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Chas. V. Pate | | | | ADDRESS (Street, city or town, state) 335 W ST N.E. | | | |
| DATE 7/17/67 | | | | DATE SIGNED 7/17/67 | | | |
| PHYSICIAN'S NAME (Type) CHAS. V. PATE | | | | ADDRESS Washington D.C. 20002 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7-19-67 | | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | 22d. LOCATION (City, town, or county) (State) Prince Georges, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Vincent | | | | 23a. REC'D BY REGISTRAR JUL 20 1967 | | 23b. REGISTRAR'S SIGNATURE Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-2 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 18 Film 393
10-5-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09925

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09930

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | | | d. STREET ADDRESS 5602 Hamilton Manor Dr. Apt. 2 | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Charlene Maria Avery | | | | 4. DATE OF DEATH Month 7 Day 24 Year 19 67 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-10-1967 | | 9. AGE (In years lost birthday) Yrs. 2 Months 14 Days 14 Hours 14 Min. | 10. IF UNDER 1 YEAR Months 2 Days 14 Hours 14 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Judson C. Avery | | | | 14. MOTHER'S MAIDEN NAME Peggy J. Fones | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Mr. Judson C. Avery (above address) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 522X IMMEDIATE CAUSE (a) Pulmonary congestion and edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SDII DUE TO (c) (Etiology undetermined) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. | | | M.D. Riverdale, Md. | | | 22. DATE SIGNED 7-25-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 7/27/67 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md. |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | | ADDRESS Mt. Rainier, Maryland | | 25a. REC'D BY REGISTRAR JUL 31 1967 | | 25b. REGISTRAR'S SIGNATURE Charles J. Jones |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09926

CERTIFICATE OF DEATH

09931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB | | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | | | d. STREET ADDRESS 7623 ARBROOTH DRIVE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) BEATRYCE FERRICK BAILEY | | | | 4. DATE OF DEATH Month JULY Day 31 Year 1967 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE CAU | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7 APR 1903 | 9. AGE (In years last birthday) 64 yrs. | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY NA | | 11. BIRTHPLACE (County & State, or foreign country) JOPLIN, MISSOURI | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ANDREW FERRICK | | | 14. MOTHER'S MAIDEN NAME | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 486 40 2406 | 17. INFORMANT FRANK BAILEY Address SAME AS #2 HUSBAND | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OVARIAN CANCER 1750 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO _____ (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct , 19 66 , to 31 Jul , 19 67 , that (he) last saw the deceased alive on 31 Jul , 19 67 , and that death occurred at 6:15 PM , from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>William H. White Jr.</i> M.D. | | | ATTENDING PHYS. <input type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED 31 Jul 67 | |
| 22c. PHYSICIAN'S NAME (Type) WILLIAM H. WHITE JR CAPT USAF MC | | | 22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8/3/67 | 23c. NAME OF CEMETERY OR CREMATORY MT. HOPE CEMETERY | 23d. LOCATION (City or town) JOPLIN, MISSOURI (County) (State) | | | | |
| 24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND | | | 25a. REC'D BY REGISTRAR DATE AUG 3 1967 | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

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MARYLAND

PRINCE GEORGES

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN lb 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover d. STREET ADDRESS 7500 Warren Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Joseph R Bailey | | 4. DATE OF DEATH Month 7 Day 21 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/15/95 |
| 9. AGE (In years last birthday) yrs. 71 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker | 11. BIRTHPLACE (County & State, or foreign country) Washington D. C. |
| 12. CITIZEN OF WHAT COUNTRY? US | | 13. FATHER'S NAME Joseph Bailey | |
| 14. MOTHER'S MAIDEN NAME Jennie Ford | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI | |
| 16. SOCIAL SECURITY NO. 577 05 8350 | | 17. INFORMANT Alice A Bailey Address Landover, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4331 CONGESTIVE HEART FAILURE DUE TO (b) ATRIAL FIBRILLATION DUE TO (c) ARTERIOSCLEROTIC C-V DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS UNKNOWN UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7-19 , 19 67 , to 7-21 , 19 67 , that (I) (we) last saw the deceased alive on 7-21 , 19 67 , and that death occurred at 7:55 PM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE C.J. Houmann | | 22b. DATE SIGNED 7-22-67 | |
| 22c. PHYSICIAN'S NAME (Type) C.J. HOUMANN | | 22d. ADDRESS RIVERDALE MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF July 24, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | 25a. REC'D BY REGISTRAR JUL 26 1967 | |
| ADDRESS Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09928

CERTIFICATE OF DEATH

09933

| | | | | | | | |
|--|------------------------------|---|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Washington, D. C. b. COUNTY 473 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c. LENGTH OF STAY IN 1b 2½ months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | | | d. STREET ADDRESS 3365 Alden Pl., N.E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Betsy Middle L. Last Barker | | | | 4. DATE OF DEATH Month July Day 31 Year 19 67 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 3/17/1891 | 9. AGE (In years last birthday) yrs. 76 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10b. KIND OF BUSINESS OR INDUSTRY unknown | | 11. BIRTHPLACE (County & State, or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Chauncey Barker | | | | 14. MOTHER'S MAIDEN NAME Emily Mary Evelyn M. Berdine | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 213-56-5885 | | 17. INFORMANT Address decedent | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH unknown unknown | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/12/ , 19 67 , to 7/31/ , 19 67 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on 7/31/1967 , and that death occurred at 7:25PM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE  | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 7/31/67 | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | | | 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF Aug 2, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | |
| 24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DATE AUG 4 1967 | | 25b. REGISTRAR'S SIGNATURE  | |

Prince Georges

U.S. Air Force (Army)

Washington, D. C.

Glenn Dale Hospital

3300 Aiken St., N.E.

Baker

Baker

July 31

3/7/50

unknown

David M. Gordon

11-20-2002

deceased

General Hospital at Washington

unknown

Mr. Walter, M.D.

Glenn Dale Hospital, Glenn Dale, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09929

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09934

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|--|--|---------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>161</u> | |
| NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp.</u> | | | | STREET ADDRESS <u>Sugar Hill Community</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>EDWARD MAC BASS</u> | | | | 4. DATE OF DEATH <u>July 3</u> 19 <u>67</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>C</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>11 Aug 1917</u> | |
| 9. AGE (In years last birthday) <u>47</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 MRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>No. CAROLINA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>EUGENE BROWN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ROSIE BASS</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of aorta</u> DUE TO <u>795.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>etiology undetermined</u> DUE TO (c) <u>inst</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county) <u>Baltimore Md.</u> | | | |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify) | | 23b. DATE THEREOF <u>7-7-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>ANAT. BORED</u> | | 23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE Md.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE <u>JUL 18 1967</u> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies Pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09930

CERTIFICATE OF DEATH

09935

| | | | | | | | | | | | | | |
|--|--------------------------------|---|---|--|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE c. LENGTH OF STAY IN 1b 1 1/2 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HYATTSVILLE NURSING HOME | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE d. STREET ADDRESS 6821 Riverdale Rd. Apt. D-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Hattie First V. Bassford Middle Last | | 4. DATE OF DEATH July Month 11 Day 1967 Year | | | | | | | | | | | |
| 5. SEX Female | 6. COLOR OR RACE Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 23, 1886 | 9. AGE (In years lost birthday) 81 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. Months Days Hours Min. | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A. | | | | | | | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 579 44 4498 B | | 17. INFORMANT John L Bassford Address Hyattsville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiac Decompensation 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (1) (this hospital) attended the deceased from April 2, 1967 , to Aug 11, 1967 , that (1) (we) last saw the deceased alive on Aug 9, 1967 , and that death occurred at 5:20 A.M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE A Deitz | | 22b. DATE SIGNED Aug 11, 1967 | | 22c. PHYSICIAN'S NAME (Type) A Deitz | | 22d. ADDRESS Pro Geo Plaza Hyattsville, Md. | | 22e. REC'D BY REGISTRAR JUL 13 1967 | | 22f. REGISTRAR'S SIGNATURE Francis J. [Signature] | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment | | 23b. DATE THEREOF July 13, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Mausoleum | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | | 24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md. | | 25. REC'D BY REGISTRAR JUL 13 1967 | | 26. REGISTRAR'S SIGNATURE Francis J. [Signature] | |

2003

CERTIFICATE OF DEATH

PRINCIPAL

DECEASED

DATE OF DEATH

BY TESTAMENTS

IN THE

BY TESTAMENTS

DECEASED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8 & 9 Film G390 7/19/67 kk

CERTIFICATE OF DEATH

09931

09936

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George County Md.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>831 Kentucky Ave SE</u> b. COUNTY <u>Wash.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt Md.</u> | | c. LENGTH OF STAY IN 1b <u>3 mos.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. DC</u> | | 47.3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Convalescent Ctr.</u> | | d. STREET ADDRESS <u>Greenbelt Rd. (7010)</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>B</u> Last <u>Becker</u> | | 4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1967</u> | |
| 5. SEX <u>7</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/16/1887</u> |
| 9. AGE (In years last birthday) <u>79</u> | | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MAY 13, 1967</u> to <u>JULY 6, 1967</u> that (I) (we) lost the deceased alive on <u>July 6, 1967</u> , and that death occurred at <u>11:40 PM</u> , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dr. D. Johnson</u> | | 22b. DATE SIGNED <u>July 6, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. D. Johnson</u> | | 22d. ADDRESS <u>11358 Cherry Hill Rd, #303, Beltsville, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>7/10/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u> | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u> |
| 24. FUNERAL DIRECTOR <u>Lee Funeral Home</u> | | 25a. REC'D BY REGISTRAR DATE <u>JUL 14 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

UNITED STATES GOVERNMENT

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|---|--|------------------------|--|
| 1. NAME OF THE ORGANIZATION OR INDIVIDUAL | | 2. ADDRESS | |
| 3. CITY | | 4. STATE | |
| 5. ZIP CODE | | 6. PHONE NUMBER | |
| 7. TITLE OF THE PROJECT | | 8. DATE OF COMPLETION | |
| 9. NAME OF THE PERSON IN CHARGE | | 10. SIGNATURE | |
| 11. ORGANIZATION | | 12. ADDRESS | |
| 13. CITY | | 14. STATE | |
| 15. ZIP CODE | | 16. PHONE NUMBER | |
| 17. TITLE OF THE PROJECT | | 18. DATE OF COMPLETION | |
| 19. NAME OF THE PERSON IN CHARGE | | 20. SIGNATURE | |
| 21. ORGANIZATION | | 22. ADDRESS | |
| 23. CITY | | 24. STATE | |
| 25. ZIP CODE | | 26. PHONE NUMBER | |
| 27. TITLE OF THE PROJECT | | 28. DATE OF COMPLETION | |
| 29. NAME OF THE PERSON IN CHARGE | | 30. SIGNATURE | |
| 31. ORGANIZATION | | 32. ADDRESS | |
| 33. CITY | | 34. STATE | |
| 35. ZIP CODE | | 36. PHONE NUMBER | |
| 37. TITLE OF THE PROJECT | | 38. DATE OF COMPLETION | |
| 39. NAME OF THE PERSON IN CHARGE | | 40. SIGNATURE | |
| 41. ORGANIZATION | | 42. ADDRESS | |
| 43. CITY | | 44. STATE | |
| 45. ZIP CODE | | 46. PHONE NUMBER | |
| 47. TITLE OF THE PROJECT | | 48. DATE OF COMPLETION | |
| 49. NAME OF THE PERSON IN CHARGE | | 50. SIGNATURE | |
| 51. ORGANIZATION | | 52. ADDRESS | |
| 53. CITY | | 54. STATE | |
| 55. ZIP CODE | | 56. PHONE NUMBER | |
| 57. TITLE OF THE PROJECT | | 58. DATE OF COMPLETION | |
| 59. NAME OF THE PERSON IN CHARGE | | 60. SIGNATURE | |
| 61. ORGANIZATION | | 62. ADDRESS | |
| 63. CITY | | 64. STATE | |
| 65. ZIP CODE | | 66. PHONE NUMBER | |
| 67. TITLE OF THE PROJECT | | 68. DATE OF COMPLETION | |
| 69. NAME OF THE PERSON IN CHARGE | | 70. SIGNATURE | |
| 71. ORGANIZATION | | 72. ADDRESS | |
| 73. CITY | | 74. STATE | |
| 75. ZIP CODE | | 76. PHONE NUMBER | |
| 77. TITLE OF THE PROJECT | | 78. DATE OF COMPLETION | |
| 79. NAME OF THE PERSON IN CHARGE | | 80. SIGNATURE | |
| 81. ORGANIZATION | | 82. ADDRESS | |
| 83. CITY | | 84. STATE | |
| 85. ZIP CODE | | 86. PHONE NUMBER | |
| 87. TITLE OF THE PROJECT | | 88. DATE OF COMPLETION | |
| 89. NAME OF THE PERSON IN CHARGE | | 90. SIGNATURE | |
| 91. ORGANIZATION | | 92. ADDRESS | |
| 93. CITY | | 94. STATE | |
| 95. ZIP CODE | | 96. PHONE NUMBER | |
| 97. TITLE OF THE PROJECT | | 98. DATE OF COMPLETION | |
| 99. NAME OF THE PERSON IN CHARGE | | 100. SIGNATURE | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09932 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09937

| | | | | | | | |
|--|--|---|--|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 12 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 2108 Ravenswood St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Foster First M. Middle Blair Last | | | 4. DATE OF DEATH July 15 Month 19 67 Day 19 67 Year | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH 14 July 1907 | | 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Yellow Cab Co. | | 11. BIRTHPLACE (State or foreign country) Alabama | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Blair | | 14. MOTHER'S MAIDEN NAME Elizabeth Moats | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 5/1471631 | | 17. INFORMANT Mrs. Mabel R. Blair - (above address) Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraberebral Hemorrhage 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. None 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None | | | |
| 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| 22. DATE SIGNED July 16, 1967 | | 23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (Acting) Cheverly, MD | | | | | |
| 24. ACTUAL SIGNATURE Cornelius J. Burns, MD EXAMINER'S NAME (Type) | | 25. ADDRESS Rock Creek Cemetery Wash., D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/18/67 | | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | | |
| 23d. LOCATION (City, town or county) (State) Wash., D.C. | | 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | 25a. REC'D BY REGISTRAR JUL 20 1967 | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

MEDICAL CERTIFICATION

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WORLDWIDE EXHIBITION

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Prince George's General Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

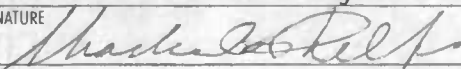

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09933

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09933

| | | | | | | | |
|---|--------------------------------|---|---------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Washington, Dist. COUNTY of Columbia | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base | | | | c. LENGTH OF STAY IN 1b 6 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews | | | | d. STREET ADDRESS 288 Yount Street | | | |
| 3. NAME OF DECEASED (Type or print) First DOROTHY Middle ELIZABETH Last BONHEIM | | | | 4. DATE OF DEATH Month July Day 12 Year 1967 | | | |
| 5. SEX Female | 6. COLOR OR RACE Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4 Sep 1934 | 9. AGE (In years lost birthday) 32 yrs. | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | | IF UNDER 24 HRS. Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY NA | | 11. BIRTHPLACE (County & State, or foreign country) Lancaster, Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Virgil Graybeal | | | | 14. MOTHER'S MAIDEN NAME Magdelin Phelan | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Jun53-Jan55 | | 16. SOCIAL SECURITY NO. 195-26-2517 | | 17. INFORMANT Husband | | Address Same as item #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma, Source Undetermined DUE TO (c) Bronchopneumonia, E-coli | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the doctor) attended the deceased from 6 July, 1967 , to 12 July, 1967 , that (I) (we) last saw the deceased alive on 12 July, 1967 , and that death occurred at 235p on the date stated above. | | | | | | | |
| 22a. SIGNATURE  | | | | 22b. DATE SIGNED 12 July 1967 | | 22c. PHYSICIAN'S NAME (Type) CHARLES D. PHELPS, CAPT, USAF, MC USAFH, Andrews AFB, Wash DC | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7/17/67 | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUTLAND ROAD, SUTLAND, MARYLAND | | | | 25a. REC'D BY REGISTRAR JUL 18 1967 | | 25b. REGISTRAR'S SIGNATURE  | |

Washington, Dist. of Columbia

Building 475, Washington DC

288 Young Street

ROBERTY ELIZABETH ROBERTY July 12 67

1929 1934 1935

USA Lancaster, Pa. 8A

Married in England

Same as item 12

Husband

1923-1925 1925-1927

Yes

Respiratory obstruction

Adenocarcinoma, Source Undetermined

Bronchopneumonia, 2-6-67

12 July 67 12 July 67

2330 2330

12 July 1967

CHARLES D. BUELL, CAPT, USAF, MC BATH, Andrews AF, Wash DC

JUL 18 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|--|-------------------------------------|--|---|--|--|--|--|--|--|
| 09934 | | | | | 09939 | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <i>Pa Geo</i> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Pa Geo</i> | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hollywood, Md</i> | | | c. LENGTH OF STAY IN 1b <i>4 yr</i> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>College Park, Md</i> | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Even Edwards Nursing Home</i> | | | | | d. STREET ADDRESS <i>4717 Secumseh st.</i> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>MARY</i> | | First <i>MARY</i> Middle <i></i> Last <i>BOSMA</i> | | 4. DATE OF DEATH <i>July 14, 1967</i> | | Month <i>July</i> Day <i>14</i> Year <i>1967</i> | | | | | |
| 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>W</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>May 2, 1876</i> | | 9. AGE (In years last birthday) <i>91</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i></i> Days <i></i> Hours <i></i> Min. <i></i> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (County & State, or foreign country) <i>Holland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | | |
| 13. FATHER'S NAME <i>Serardus M. VAN DEURSEN</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Geertruida Kewiersma</i> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <i></i> | | 17. INFORMANT <i>Theodore Bosma College Park, Md</i> Address <i></i> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>54 hrs</i> | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4200</i> <i>Cerebral Hypocardial Failure</i> | | | | | | | | | | | |
| Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerotic cardiac</i> | | | | | | | | | | | |
| (c) <i>& Cerebral vascular disease</i> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. <i>10</i> p.m. <i></i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Ring</i> | | 20f. (City or town) <i>College Park, Md</i> (County) <i></i> (State) <i>Md</i> | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>July 12, 1967</i> to <i>July 14, 1967</i> , that (I) (we) last saw the deceased alive on <i>July 12, 1967</i> , and that death occurred at <i>5:37</i> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <i>W.L. Etienne</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <i>7-14-67</i> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <i>W.L. ETIENNE</i> | | | | 22d. ADDRESS <i>College Park, Md</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>July 17, 1967</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet Cemetery</i> | | 23d. LOCATION (City, town or county) (State) <i>Washington D. C.</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i> | | | | 25a. REC'D BY REGISTRAR <i>JUL 17 1967</i> DATE <i></i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | |

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[Handwritten signatures and notes, mostly illegible due to blurriness]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

09935 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #11 infor. taken from prev. birth cert. pn

11361

CERTIFICATE OF DEATH

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b 1 hour | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights 16-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 2440 Rochelle Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Bradford | | | | 4. DATE OF DEATH Month Day Year July 27 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/27/67 | | 9. AGE (In years last birthday) yrs. 1 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Cheverly, Pr. Geo. Co. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Norman A. Bradford | | | | 14. MOTHER'S MAIDEN NAME Jeanne Bennett | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Jeanne Bennett, Mother | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 7615 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Immaturity DUE TO Partial (c) Premature Separation of placenta | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pl. had fall down steps injured abdomen | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (1) (this hospital) attended the deceased from 7-18-1967 to 7-27-1967 and that death occurred at 7:10 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Dr. Mark Pillor | | | | 22b. DATE SIGNED 7-27-67 | | 22c. PHYSICIAN'S NAME (Type) Dr. Mark Pillor | |
| 22d. ADDRESS 7200 Marlboro Pike, District Hgts., Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 8/5/67 | | 23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. | | 23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland | |
| 24. FUNERAL DIRECTOR Adity W. Penn, Jr., Admin., Cheverly, Md. | | | | 25a. REC'D BY REGISTRAR DATE AUG 9 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09936

CERTIFICATE OF DEATH

09940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|---|--|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>3 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u> d. STREET ADDRESS <u>4305 57th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl (A)</u> Last <u>Brais</u> | | | 4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>19 67</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>7/11/67</u> | 9. AGE (In years lost birthday) yrs. <u>16 1/2</u> IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> | IF UNDER 24 HRS. Hours <u>3</u> Min. <u>16</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Pr. Georges Co. Maryland</u> | | | |
| 13. FATHER'S NAME <u>Kenneth David Brais</u> | | | 14. MOTHER'S MAIDEN NAME <u>Beverly Ann Elliott</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Mother</u> <u>Same as above</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO (b) <u>Premature delivery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/11</u>, 19 <u>67</u>, to <u>7/11</u>, 19 <u>67</u>, that (I) (we) last saw the deceased alive on <u>7/11</u>, 19 <u>67</u>, and that death occurred at <u>4:30 M.</u> from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Dr. Manuel Porres</u> | | | 22b. DATE SIGNED <u>7/13/67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Dr. Manuel Porres</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | | 23b. DATE THEREOF <u>7/22/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Prince George's Gen. Hosp. Cheverly PG Maryland</u> | | |
| 24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr., Admin.</u> | | | 25a. REC'D BY REGISTRAR <u>JUL 26 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

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THE CASE OF DEATH

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George's General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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|---|----------------------------------|---|------------------------------------|
| 09937 | | 09941 | |
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 Hr. 30 mins. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 4305 57th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy (B) Brais | | 4. DATE OF DEATH Month Day Year July 11 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/11/67 |
| 9. AGE (In years lost birthday) yrs. 2 / 130 | | 10. IF UNDER 1 YEAR Months Days 2 / 130 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Prince Georges Co. Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Kenneth David Brais | | 14. MOTHER'S MAIDEN NAME Beverly Ann Elliott | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mother | | Address Same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Premature delivery DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/11 , 19 67 , to 7/11 , 19 67 that (I) (we) last saw the deceased alive on 7/11 , 19 67 , and that death occurred at 4:30 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Dr. Manuel Porres | | 22b. DATE SIGNED 7/13/67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Manuel Porres | | 22d. ADDRESS 6315 Landover Rd., Landover, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 7/22/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hosp. Cheverly PG Maryland | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR Harry W. Penn, Jr., Adm., Cheverly, Md. | | 25a. REC'D BY REGISTRAR JUL 26 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles J. Jones | | DATE | |

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TABLE 1

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09938

CERTIFICATE OF DEATH

09942

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| 1. PLACE OF DEATH PRINCE GEORGE'S | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | |
| a. COUNTY PALMER PARK, PR. GEO. | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park | a. STATE Maryland | b. COUNTY Pro Georges |
| c. LENGTH OF STAY IN lb | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park Md. | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7343-85th Ave. | d. STREET ADDRESS 7343 85th Ave. | | |
| 3. NAME OF DECEASED (Type or print) Michael W. Britcher Sr | | 4. DATE OF DEATH July 31, 1967 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 31, 1907 |
| 9. AGE (In years last birthday) 59 yrs. | | IF UNDER 1 YEAR: Months 5 Days 9 Hours 16 Min. 16.1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouse Superintendent | | 10b. KIND OF BUSINESS OR INDUSTRY wholesale food | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Hiram Britcher | | 14. MOTHER'S MAIDEN NAME Blanche M Bowers | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 176 01 0006 | |
| 17. INFORMANT Alice T Britcher | | Address Palmer Park, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, brain metastatic 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, rt. lung DUE TO (c) 5 yrs. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from FEB , 19 67 , to July 31 , 19 67 , that (I) (we) last saw the deceased alive on July 29 , 19 67 , and that death occurred at 5 P.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Irvin M. Grassgreen | | 22b. DATE SIGNED 7-31-67 | |
| 22c. PHYSICIAN'S NAME (Type) IRVIN M. GRASSGREEN | | 22d. ADDRESS MT. RAINIER, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/3/67 | 23c. NAME OF CEMETERY OR CREMATORY Mifflinburg | 23d. LOCATION (City or Town) (County) (State) Mifflinburg, Pa. |
| 24. FUNERAL DIRECTOR GASCH'S | | 25a. REC'D BY REGISTRAR HYATTSVILLE, MARYLAND | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE AUG 4 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Handwritten notes and diagrams on lined paper, including a large circular diagram with internal lines and labels, and various scribbles and markings.

Vertical text on the right margin, possibly a page number or date, and a small circular mark near the bottom right corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|--|--|---|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 09939 CERTIFICATE OF DEATH 09943 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47-3 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home | | | | | d. STREET ADDRESS 3220 Gee Street S.E. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Louis W Bridgett | | | 4. DATE OF DEATH Month Day Year July 11th 19 67 | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH 3-20-1892 | | 9. AGE (In years last birthday) yrs. 75 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Carpenter | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME Daniel Bridgett | | | | | 14. MOTHER'S MAIDEN NAME Mary | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. 79-14-7791A | | 17. INFORMANT Myrtle M. Bridgett Same as # 2 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infection & Pneumonitis DUE TO (c) Carcinoma of lung. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Ischemia & A.S.H.D. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr 3 wks 2 mo | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/11/67, 1967, to 7/11/67, 1967, that (I) we last saw the deceased alive on 7/11/67, 1967, and that death occurred on 7/11/67, 1967, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Kelvin L Minchin | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 7/11/67 | | |
| 22c. PHYSICIAN'S NAME (Type) KELVIN L MINCHIN | | | | | 22d. ADDRESS 6400 MARLBORO PIKE SE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 7-12-1967 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION (City or Town) (County) (State) Suitland Pr Geo Md | | |
| 24. FUNERAL DIRECTOR Matthew 131-11th St. S.E. D.C. | | | | | 25a. REC'D BY REGISTRAR DATE JUL 14 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

WILLIAM W. DUNN, JR. (1915-1991)

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|--|---------------------------|--|--------------------------------------|
| 09940 | | 09944 | |
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u> | |
| c. LENGTH OF STAY IN lb | | d. STREET ADDRESS <u>Box 133 Route 450</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Rosie Ann Brooks</u> | | 4. DATE OF DEATH <u>July 27 1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 10, 1895</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | 10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give usual of work done during most of working life, even if retired) <u>Retired Cook</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Private Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Benjamin Brooks</u> | | 14. MOTHER'S MAIDEN NAME <u>Henrietta ?</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Sylvester Canig</u> | | Address <u>-</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4201</u> DUE TO (b) <u>Partial Heart Block</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>Hypertensive Cardio-vascular disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>2 years</u> <u>5 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Generalized arteriosclerosis</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 29, 1967</u> to <u>July 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 24, 1967</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Theodus R. Conner</u> M.D. | | 22b. DATE SIGNED <u>July 27, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Theodus R. Conner</u> | | 22d. ADDRESS <u>1241 New Jersey Ave., N.W., Wash. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-31-67</u> | | 23b. DATE THEREOF <u>7-31-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u> | | 23d. LOCATION (City, town or county) (State) <u>Washington DC</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington & Sons</u> ADDRESS <u>4925 Penna Ave NE</u> | | 25a. REC'D BY REGISTRAR <u>AUG 1 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | |

[Faint, illegible handwriting throughout the page]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09941

CERTIFICATE OF DEATH

09945

| | | | | | | | |
|---|--|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WASHINGTON b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE | | | c. LENGTH OF STAY IN 1b 1 DAY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DISTRICT OF COLUMBIA | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | | | d. STREET ADDRESS 13 HAMMOCK GREEN SW | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First SHERYL Middle LEE Last BRYAN | | | | 4. DATE OF DEATH Month JULY Day 20 Year 19 67 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE CAU | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 30 JUN 67 | |
| 9. AGE (In years last birthday) 21 yrs. | | IF UNDER 1 YEAR Months 21 Days 21 Hours 21 Mins. | | 11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE, MD | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | | 13. FATHER'S NAME ROBERT GLEN BRYAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT FATHER Address SAME AS # 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus DUE TO 751.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Meningocele DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 0 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 19, 1967 , to July 20, 1967 , that (I) (we) last saw the deceased alive on July 20, 1967 , and that death occurred at 8:20 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Phillip Steiner | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED July 29, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) PHILLIP STEINER, CAPT, USAF, MC | | | | 22d. ADDRESS Andrews Air Force Base Hospital | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL | | 23b. DATE THEREOF 7/24/67 | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL | | 23d. LOCATION (City or Town) (County) (State) ARLINGTON VIRGINIA | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm Address Federal Home 4308 Suitland Road, Suitland, Maryland | | | | 25a. REC'D BY REGISTRAR DATE JUL 25 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09942

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09946

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Stanley Eugene Burrell | | 4. DATE OF DEATH 7 20 1967 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-26-1936 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY ICE CREAM CO. | |
| 11. BIRTHPLACE (State or foreign country) So. CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CH'S B. BURRELL | | 14. MOTHER'S MAIDEN NAME MAY WINKLER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT MRS JEANE K. BURRELL | | Address 5711 NICHOLSON RIVERDALE, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Skull fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) From trauma - auto accident DUE TO (c) — | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which ran back of trailer truck | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:30pm 7-19-1967 | | 20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4557 Tanglewood Dr., Bladensburg, Md. | | 20f. (City or town) (County) RG. (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7-23-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY SPARTANBURG CEM. | | 23d. LOCATION (City or Town) (County) (State) SPARTANBURG So. CAR. | |
| 24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD. | | 25a. REC'D BY REGISTRAR JUL 24 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | 22. DATE SIGNED 7-20-67 | |

THE UNIVERSITY OF CHICAGO

1950

Department of Chemistry

Chicago, Illinois

George S. Hammond

Professor

Department of Chemistry

Chicago, Illinois

Dear Mr. Hammond:

I am very pleased to hear from you.

I am sure you will find the enclosed of interest.

Sincerely,
George S. Hammond

Very truly yours,



George S. Hammond

Enclosed for you are two copies of a report on the progress of the work in the Hammond Laboratory during the past year.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09943

09947

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b DOA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Roy Middle Eden Last Campbell | | | | 4. DATE OF DEATH Month 7 Day 30 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-24-1912 | 9. AGE (In years lost birthday) 54 yrs. | IF UNDER 1 YEAR Months 5 Ooys 10 Hours 15 Min. | | IF UNDER 24 HRS. Hours 15 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS OPERATOR | | | 10b. KIND OF BUSINESS OR INDUSTRY D.C. TRANSIT | | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME WISSIE CAMPBELL | | | | 14. MOTHER'S MAIDEN NAME LILA WEAKLEY | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 577 052898 | | 17. INFORMANT GRACE E. CAMPBELL | | Address SAME AS #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes over 7 mo. |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | | | 22. DATE SIGNED 7-31-67 | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 8-3-1967 | | 23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY | | 23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MARYLAND | |
| 24. FUNERAL DIRECTOR W.W. CHAMBERS GO. RIVERDALE, MARYLAND | | | | 25a. REC'D BY REGISTRAR AUG 4 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09944

CERTIFICATE OF DEATH

09948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr</u> c. CITY OR TOWN <u>Accokeek</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u> | | c. LENGTH OF STAY IN IB <u>9 da.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek MD</u> | | d. STREET ADDRESS <u>15741-Livingston Rd</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Regent Nursing + Rehab Center</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>William T. Cauffman SR.</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1967</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>7-30-1896</u> | |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | 10. UNDER 1 YEAR Months _____ Days _____ | | 11. IF UNDER 24 HRS. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed Bicycle Shop</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bicycle Shop</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>William F. Cauffman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie B. Pierce</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>578-56-9433A</u> | | 17. INFORMANT Address <u>Wm. T. Cauffman Jr. Same As # 2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema</u> (b) <u>Rt. Hilar mass - Probably tumor</u> (c) <u>Superior Vena Cava Syndrome</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>months</u> <u>months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cor Pulmonale</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6-26-67</u> , 19 <u>67</u> , to <u>7-4-67</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>7-4-67</u> , 19 <u>67</u> , and that death occurred at <u>3:35</u> AM, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>W B Sheer</u> | | | | 22b. DATE SIGNED <u>7-4-67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER</u> | |
| 22d. ADDRESS <u>6400 MARLBORO PIKE S.E. NASH. D.C. 20028</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7-6-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Simmons Bros.</u> | | | | 25a. REC'D BY REGISTRAR <u>1661-Good Hope Rd SE Wash DC</u> | | 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11379

09945

CERTIFICATE OF DEATH

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 hrs. 26 mins d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf d. STREET ADDRESS Rt. #1, Box 80, Berry Hill Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy "A" Claggett | | 4. DATE OF DEATH Month Day Year July 30, 1967 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 30, 1967 |
| 9. AGE (In years lost birthday) yrs. 16 1 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Veronica Claggett | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625 Prematurity - 740 grams DUE TO (b) atelectasis, bi-lateral DUE TO (c) lost Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that xx (this hospital) attended the deceased from July 30, 1967 , to July 30, 1967 , that xx (we) last saw the deceased alive on July 30, 1967 , and that death occurred at 5:15 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Patrick A. Reardon 22c. PHYSICIAN'S NAME (Type) Patrick A. Reardon, M. D. | | 22b. DATE SIGNED PM ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Prince Georges General Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE THEREOF 8/5/67 | 23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. | 23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland |
| 24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland | | 25a. REC'D BY REGISTRAR AUG 9 1967 | 25b. REGISTRAR'S SIGNATURE Charles Judge |

100-100000

CERTIFICATE OF DEATH

100-100000

100-100000

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

Veronica [illegible]

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09946

CERTIFICATE OF DEATH

11380

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|---|------------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland by COUNTY Prince Georges Chas. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b 2 hrs. 2 mins. | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | d. STREET ADDRESS Rt. #1, Box 80, Berry Hill Drive | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy "B" Claggett | | | | 4. DATE OF DEATH Month Day Year July 30, 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH July 30, 1967 | | 9. AGE (In years lost birthday) yrs. 16 1 | IF UNDER 1 YEAR Months Days 2 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Md. P.G.C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME Veronica Claggett | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 600 grams 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atelectasis - bi-lateral DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (a) (this hospital) attended the deceased from July 30, 1967 , to July 30, 1967 , that (b) (we) last saw the deceased alive on July 30, 1967 , and that death occurred at 12:15 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Patrick A. Reardon M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Patrick A. Reardon, M.D. | | | | 22d. ADDRESS Prince Georges General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 8/5/67 | | 23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly | | 23d. LOCATION (City or Town) (County) (State) PG Maryland | |
| 24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland | | | | 25a. REC'D BY REGISTRAR AUG 9 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

7-2445-13

ON THE 10th DAY OF JULY 1957

STATEMENT OF WORK

100-100000

TO THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION

FROM THE SAC, NEW YORK

SUBJECT: [REDACTED]

DATE: JULY 10, 1957

RE: [REDACTED]

Enclosed for the Bureau are:

1. [REDACTED]

2. [REDACTED]

3. [REDACTED]

4. [REDACTED]

5. [REDACTED]

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09947

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #11 & 12 Film #G390 7/10/67 pc

CERTIFICATE OF DEATH

09949

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|--|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b 4 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47-3 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | d. STREET ADDRESS 4223 Alabama Ave. S.E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Josephine E. Collins | | | | 4. DATE OF DEATH Month Day Year July 2 1967 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 17 Jan. 1911 | | 9. AGE (In years lost birthday) yrs. 56 | 10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Samuel Bonaveries | | | | 14. MOTHER'S MAIDEN NAME Ruth Skinner | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Eugene J. Collins 4223 Alabama Ave S E | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive cardiovascular disease DUE TO (c) 10 yrs. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7-1 , 19 67 , to 7-2 , 19 67 , that (I) (we) last saw the deceased alive on 7-1 , 19 67 , and that death occurred at 6.00 AM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Peter Guas | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7-5-67 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Suitland Maryland | |
| 24. FUNERAL DIRECTOR Robert E. Williams | | | | 25a. REC'D BY REGISTRAR DATE JUL 5 1967 | | 25b. REGISTRAR'S SIGNATURE James Judge | |

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]
DATE: 1/10/64
BY: [Illegible]

1. [Illegible]
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09948

CERTIFICATE OF DEATH

09950

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|--|--------------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base | | | | c. LENGTH OF STAY IN 1b 1 Day | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews | | | | d. STREET ADDRESS 7916 Morris Ave, Apt 207 | | | |
| 3. NAME OF DECEASED (Type or print) First LEE Middle SONG Last COLLINS | | | | 4. DATE OF DEATH Month July Day 4 Year 1967 | | | |
| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3 July 1967 | | 9. AGE (In years lost birthday) - yrs. | IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA | | 10b. KIND OF BUSINESS OR INDUSTRY NA | | 11. BIRTHPLACE (County & State, or foreign country) Prince Georges, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME RICHARD ASHLEY COLLINS | | | | 14. MOTHER'S MAIDEN NAME CHONG OK SONG | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. NA | | 17. INFORMANT Address Father - same as item 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 7735 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from 3 July , 19 67 , to 4 July , 19 67 that (we) last saw the deceased alive on 4 July , 19 67 , and that death occurred at 1205a , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Saul H. Saperstein</i> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 4 July 1967 | |
| 22c. PHYSICIAN'S NAME (Type) PAUL PERTSTEIN, CAPT, USAF, MC | | | | 22d. ADDRESS USAFH Andrews AFB, Wash DC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 28 JUL 67 | | 23c. NAME OF CEMETERY OR CREMATORY PUBLIC CREMATION | | 23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C. | |
| 24. FUNERAL DIRECTOR <i>Carl F. Ruff</i> | | | | 25a. REC'D BY REGISTRAR DATE JUL 21 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i> | |

01-14-17 11:44 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

09943

MARYLAND STATE DEPARTMENT OF HEALTH

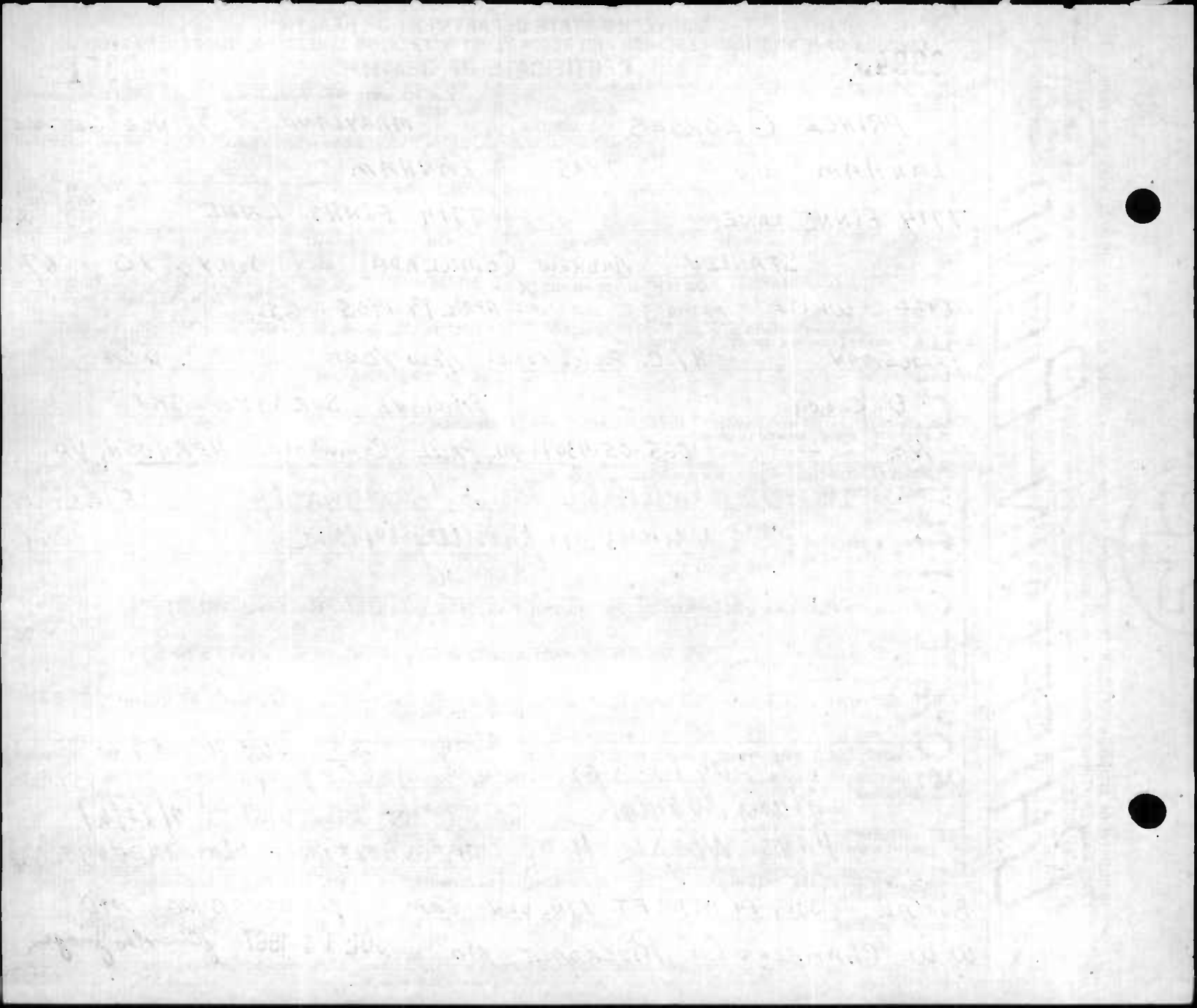
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09951

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LANHAM MD.</u> | | | | c. LENGTH OF STAY IN 1b <u>7 YRS</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7714 FINNS LANE.</u> | | | | d. STREET ADDRESS <u>7714 FINNS LANE</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>STANLEY ANDREW COMULADA</u> | | | | 4. DATE OF DEATH Month <u>JULY</u> Day <u>10</u> Year <u>1967</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>APRIL 19 1905</u> | |
| 9. AGE (In years last birthday) <u>62</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y.C. POLICE FORCE</u> | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>PAULINE SURDAKOWSKI</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>065-05-4307</u> | | 17. INFORMANT <u>M. PAUL COMULADA</u> Address <u>HERNDON, VA.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melastatic Adeno Carcinoma of</u> <u>1991</u> DUE TO <u>unknown primary lesion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO <u> </u> (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>6 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>62</u> , to <u>July 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 10</u> , 19 <u>67</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Hans Wodak</u> | | | | 22b. DATE SIGNED <u>7/12/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>HANS WODAK M.D.</u> | | | | 22d. ADDRESS <u>GREENBELT PROF. BLDG. GREENBELT, MD.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>JULY 14 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u> | | 23d. LOCATION (City, town or county) (State) <u>BLADENSBURG, MD.</u> | |
| 24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. RIVERDALE, MD</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 14 1967</u> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~card~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09950

Item #9 Film #G391 7/31/67 ph

CERTIFICATE OF DEATH

09952

| | | | | | | | |
|---|--|--|--|---|--|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON | | | | c. LENGTH OF STAY IN 1b 55 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PINE VIEW GARDENS HEALTH CARE CENTER | | | | d. STREET ADDRESS 5300 Ludlow Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Elizabeth Middle M. Last Conley | | | | 4. DATE OF DEATH Month July Day 25 Year 1967 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 09-24-1936 | |
| 9. AGE (In years last birthday) 31/80 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 | | IF UNDER 24 HRS. Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker | | | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (County & State, or foreign country) Halstead Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Edward Gilcrest | | | | 14. MOTHER'S MAIDEN NAME Mary Ellen Cook | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 105-14-1276 | | 17. INFORMANT Daughter-in-law Address same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-1 , 19 67 , to 7-25 , 19 67 that (I) (we) last saw the deceased alive on 7-25 , 19 67 , and that death occurred at 5:54 A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Alfred R. Lapan, MD | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) ALFRED R. LAPAN, MD | | | | 22d. ADDRESS CLINTON, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 7/26/67 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary | | 23d. LOCATION (City or Town) (County) (State) Johnson City, NY | |
| 24. FUNERAL DIRECTOR McChambers Co. 1400 Chapin St | | | | 25a. REC'D BY REGISTRAR DATE JUL 27 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09951

09953

| | | | | | | | |
|--|--|--|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b 22 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS 4203 71st. Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Helen Middle J Last Conway | | | | 4. DATE OF DEATH Month 7 Day 16 Year 19 67 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 20 April 1916 | |
| 9. AGE (In years lost birthdays) 51 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Sec. | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Public Health | | 11. BIRTHPLACE (State or foreign country) Greenfield, Mass. | |
| 13. FATHER'S NAME Stanley Wisniewski | | | | 14. MOTHER'S MAIDEN NAME Rosemary Drinzek | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 016-07-0784 | | 17. INFORMANT Mr. James J. Conway Address (above address) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma DUE TO And Cerebral contusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) From Trauma - fall at home. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 22 days 22 days | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 6-24- 1967 p.m. unknown | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) same as #2 | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county) 7-18-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/21/67 | | 23c. NAME OF CEMETERY OR CREMATORY Mater Dolorosa Cem. | | 23d. LOCATION (City or Town) (County) (State) Greenfield, Mass. | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | | | 25a. REC'D BY REGISTRAR JUL 20 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09952

CERTIFICATE OF DEATH

09954

| | | | |
|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LAUREL c. LENGTH OF STAY IN b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) LAUREL GENERAL HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis Junction, Jessup, Md. d. STREET ADDRESS RFD a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MARY ELLEN CRAIG | | 4. DATE OF DEATH Month July Day 3 Year 1967 19 | |
| 5. SEX Female | 6. COLOR OR RACE Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 26, 1886 |
| 9. AGE (In years last birthday) 80 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 11. IF UNDER 24 HRS. Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - - - | |
| 11. BIRTHPLACE (County & State, or foreign country) SA KRESGEVILLE, PENNA. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Henry Kreger | | 14. MOTHER'S MAIDEN NAME Susan Baumgartner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) - - - - - | | 16. SOCIAL SECURITY NO. 168-32-0516 | |
| 17. INFORMANT Mrs. Carl Yenser, Same as #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis DUE TO (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) - - - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - - - | | INTERVAL BETWEEN ONSET AND DEATH 20 hrs 20 yrs | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 1965 , to 7-3-1967 , that (I) (we) last saw the deceased alive on 7-3-1967 , and that death occurred at 8 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Frank L. Weaver, M.D. | | 22b. DATE SIGNED 7-3-67 | |
| 22c. PHYSICIAN'S NAME (Type) Frank L. Weaver, M.D. | | 22d. ADDRESS Laurel, Maryland 20810 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF July 7, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Towamensing Cemetery | | 23d. LOCATION (City, town or county) (State) Carbon County, Penna | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Harold S. Wade, Laurel, Maryland | | 25a. REC'D BY REGISTRAR JUL 25 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only event within 72 hours after death.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> | | c. LENGTH OF STAY IN 1b <u>DOA</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u> | | d. STREET ADDRESS <u>Brentwood md</u> | |
| 3. NAME OF DECEASED (Type or print) <u>CHARLES RUSSELL CURTIS</u> | | 4. DATE OF DEATH <u>July 7 1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-27-1906</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Supervisor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Gov</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington DC</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Walter Curtis</u> | | 14. MOTHER'S MAIDEN NAME <u>SALLY DALTON</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>1928-1930</u> | | 16. SOCIAL SECURITY NO. <u>578-01-6495</u> | |
| 17. <u>Charles Russell Curtis Jr</u> <u>3615 Deon ST Hyattsville md</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u> DUE TO <u>years</u> (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-7-67 | |
| EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Dayton Watkins</u> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>53 Dr Annapolis</u> | |
| | | Address (Street, city, town, or county) <u>Bladensburg md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>JULY 10 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u> | 23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG MD</u> |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 11 1967</u> | |
| ADDRESS <u>RIVERDALE, MD</u> | | 25b. REGISTRAR'S SIGNATURE <u>James Judge</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G391 8/11/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09954

09957

FOR STATE
HEALTH DEPT

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

4 hours

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Coral Hills

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George General Hospital

d. STREET ADDRESS

5322 Q Street, S.E.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED

(Type or print)

First Anthony

Middle

Dal Molin

Last

4. DATE OF DEATH

Month

Day

Year

7

24

19 67

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1910

9. AGE (In years last birthday)

53 56

10. IF UNDER 1 YEAR

Months Days Hours Min.

11. IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Marble worker

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Angelo DalMolin

14. MOTHER'S MAIDEN NAME

Maria ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Elio DalMolin Same As # 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage

2022x DUE TO Aortic aneurysm ruptured into jejunum

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

5 hours

5 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While ☐ Not While ☐ at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

John Kehoe, M.D. Riverdale, Md.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED

7-25-67

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

7/27/67

23c. NAME OF CEMETERY OR CREMATORY

Mt Olivet Cemetery

23d. LOCATION (City or town)

Washington D. C.

24. FUNERAL DIRECTOR

Robert E. Wilhelm Funeral Home

4308 Suitland Road, Suitland, Maryland

25a. REC'D BY REGISTRAR

JUL 27 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO
LIBRARY

Division of the

University of Chicago

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | |
|--|-------------------------------|--|---------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 35 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | d. STREET ADDRESS 6101 Jay Street | | | |
| 3. NAME OF DECEASED (Type or print) First Annie Middle Cross Last Deal | | | | 4. DATE OF DEATH Month July Day 4 Year 19 67 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10 April 1905 | 9. AGE (In years last birthday) 62 yrs. | IF UNDER 1 YEAR Months 2 Days 16 Hours 1 Min. | | IF UNDER 24 HRS. Hours 1 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY Private Home | | 11. BIRTHPLACE (County & State, or foreign country) Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Walter Fletcher | | | | 14. MOTHER'S MAIDEN NAME Jane Deal | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Mary Deal Address 515-59th St. N.E. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bone Metastasis DUE TO (c) Cachexia | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 months One Month | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/31/67 , 19 7/4 , 19 67 that (I) (we) last saw the deceased alive on 7/4 , 19 67 , and that death occurred at 9, 30PM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE [Signature] | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 7/5/67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Ohannes Sahakyan | | | | 22d. ADDRESS 5813 Landover Rd., Cheverly, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 7-8-67 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony | | 23d. LOCATION (City or Town) (County) (State) Highland Park Md | |
| 24. FUNERAL DIRECTOR H.S. Washington & Sons | | | | ADDRESS 4945 Deane Ave | | 25a. REC'D BY REGISTRAR JUL 10 1967 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

STATEMENT OF FACTS

1. Name of the person or persons: John Doe

2. Address: 123 Main Street, New York, N.Y.

3. Date of birth: 10/10/1900

4. Occupation: Student

5. Date of statement: 10/10/1900

6. Name of the person or persons: John Doe

7. Address: 123 Main Street, New York, N.Y.

8. Date of birth: 10/10/1900

9. Occupation: Student

10. Date of statement: 10/10/1900

11. Name of the person or persons: John Doe

12. Address: 123 Main Street, New York, N.Y.

13. Date of birth: 10/10/1900

14. Occupation: Student

15. Date of statement: 10/10/1900

16. Name of the person or persons: John Doe

17. Address: 123 Main Street, New York, N.Y.

18. Date of birth: 10/10/1900

19. Occupation: Student

20. Date of statement: 10/10/1900

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09956

09958

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|---|--|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie d. STREET ADDRESS 12516 Kavanaugh Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Octave Middle (none) Last De Carre | | | 4. DATE OF DEATH Month 7 Day 28 Year 1967 | | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-3-1883 | 9. AGE (In years last birthday) 83 yrs. | 10. IF UNDER 1 YEAR Months 0 Days 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY - - - | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Alfred Decarre | | | 14. MOTHER'S MAIDEN NAME Rosa Reilly | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I; WW II | | 16. SOCIAL SECURITY NO. 577-50-8112 | 17. INFORMANT Address Miss Suzanne Decarre- See item #2 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular occlusion 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes over 6 mo. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>John Kehoe</i> M.D. EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED 7-29-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8-1-1967 | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem. Arlington, Va. | 23d. LOCATION (City or Town) (County) (State) | | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC. | | 25a. REC'D BY REGISTRAR DATE AUG 2 1967 | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09957

09959

| | | | | | | | |
|--|-------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b DOA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Moe Middle Maurice Last DECKLER | | | | 4. DATE OF DEATH Month 7 Day 29 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 26 June 1904 | 9. AGE (In years lost birthday) 63 yrs. | IF UNDER 1 YEAR Months 7 Days 29 Hours 19 Min. 67 | IF UNDER 24 HRS. Hours 19 Min. 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber | | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Jacob Deckler | | | | 14. MOTHER'S MAIDEN NAME Rose Ruben | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 114 12 5364 | | 17. INFORMANT Ruby P. Deckler Same As # 2 Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. M.D. | | | | 22. DATE SIGNED 7-30-67 | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/1/67 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home ADDRESS 4308 Suitland Road, Suitland, Maryland | | | | 25a. REC'D BY REGISTRAR AUG 2 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09958

09960

| | | | | | | | |
|--|----------------------------------|---|--------------------------------------|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN b DOA | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS 3509 Hubbard Road | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Patricia Louise DePietro | | | | 4. DATE OF DEATH Month Day Year 7 17 19 67 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 14 Jan. 1942 | | 9. AGE (In years lost birthday) 25 yrs. | 10. UNDER 1 YEAR Months Days 16 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TBM Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Federal Reserve | | 11. BIRTHPLACE (State or foreign country) Arizona | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Robert L. Stewart | | | | 14. MOTHER'S MAIDEN NAME Virginia M. Hawwen | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) xxx | | 16. SOCIAL SECURITY NO. xxxxxx 569-58-3904 | | 17. INFORMANT Address Anthony T. DePietro Husband Same as #2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 8234 DUE TO Trauma - auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which went out of control and struck a tree. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:32am p.m. 7-17- 1967 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 214 & Largo Road, Largo, Md. P.G. | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | M.D. John Kehoe, M.D. Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 7-18-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/19/67 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor, Maryland | |
| 24. FUNERAL DIRECTOR GASCH'S | | ADDRESS HYATTSVILLE, MARYLAND | | 25. REC'D BY REGISTRAR JUL 21 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

UNITED STATES DEPARTMENT OF JUSTICE

Washington, D.C. 20535

Memorandum for the Director

Subject: [Illegible]

Reference is made to [Illegible]

On [Illegible]

Very truly yours,

[Illegible Signature]

[Illegible Stamp]

Approved for release by [Illegible]

DATE: [Illegible]

7-11-77

John Edgar Hoover, Director

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

JUL 21 1977

WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove/capcan papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Body Released by Prince Georges Co. Health Officer R. H. Hines

09959

CERTIFICATE OF DEATH

09961

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges Co. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Pr George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5803 - 15th Place | | | | d. STREET ADDRESS 5803 - 15th Place | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Vera Middle Renee Last Renee | | | | 4. DATE OF DEATH Month July Day 2 Year 1967 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 4, 1891 | 9. AGE (In years last birthday) 75 yrs. | IF UNDER 1 YEAR Months 1 Days 18 Hours 15 Min. | | IF UNDER 24 HRS. Hours 15 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (County & State, or foreign country) Ukraine | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Andrew Kraus | | | | 14. MOTHER'S MAIDEN NAME Unobtainable | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 138-42-77 | | 17. INFORMANT Mrs. Helene C. Ciolek Address 5803 - 15th Pl W. Hyattsville Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema carcinoma of Gall Bladder 1551 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) w/ metastasis DUE TO (c) surgery 1/25/67 - dependent carcinoma | | | | | | INTERVAL BETWEEN ONSET AND DEATH 13 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/20/1966 , to 7/2/1967 , that (I) (we) last saw the deceased alive on 3/26/1967 , and that death occurred at 11:30 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Howard T. Morse M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 7/2/67 | |
| 22c. PHYSICIAN'S NAME (Type) Howard T. Morse | | | | 22d. ADDRESS 7030 Carroll Ave Takoma Park Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/5/67 | | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | 23d. LOCATION (City or Town) (County) (State) Washington, D. C. | |
| 24. FUNERAL DIRECTOR The S.H. Hines Co. | | | | ADDRESS Washington, D. C. | | 25a. REC'D BY REGISTRAR JUL 5 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09960

CERTIFICATE OF DEATH

09962

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|---|----------------------------------|---|-----------------------------------|--|---|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi d. STREET ADDRESS 9321 Lymont Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ollie T. Driskill | | | | 4. DATE OF DEATH Month Day Year July 10, 1967 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/8/88 | | 9. AGE (In years last birthday) 79 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (County & State, or foreign country) Va | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME William Brandon | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Tacker | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Ruth Berkley | | Address Richmond Va. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli 5400 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bleeding gastric ulcer (24 hour post-surgical status) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (husband) attended the deceased from July 8, 1967 , to July 10, 1967 , that (I) (husband) last saw the deceased alive on July 10, 1967 , and that death occurred at 8:55 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Aaron Deitz | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 7-1067 | | 22b. DATE SIGNED 7-10-67 | |
| 22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D. | | | | 22d. ADDRESS 5802 Baltimore Ave. Hyattsville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF JULY 13, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY FAMILY CEMETERY | | 23d. LOCATION (City or Town) (County) (State) DRAKES BRANCH CHARLOTTE VA. | |
| 24. FUNERAL DIRECTOR Francis Anacho Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DATE JUL 13 1967 | | 25b. REGISTRAR'S SIGNATURE Francis Anacho | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09961

CERTIFICATE OF DEATH

09963

| | | | | | | | |
|--|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morningside Md.</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5604 Lano Rd.</u> | | | | d. STREET ADDRESS <u>5604 Lano Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Duffy</u> Last <u>Duffy</u> | | | | 4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1967</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JUNE 18, 1904</u> | 9. AGE (In years last birthday) <u>63</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sexton</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>WILLIAM J. DUFFY</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH KENNEDY</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>LOUISE DUFFY SAME AS # 2</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X SUFFOCATION</u> DUE TO <u>RETAINED SECRETION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CARCINOMA OF LUNG.</u> (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>2.3 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/7</u> , 19 <u>67</u> , to <u>7/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/29</u> , 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Alfred L. Lapin</u> | | | | 22b. DATE SIGNED <u>7/29/67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Alfred L. Lapin</u> | |
| 22d. ADDRESS <u>3231 SUPERIOR LANE, Bowie Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>8/2/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State) <u>CLINTON, PRINCE GEORGES, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Robert E. Wilhelm</u> ADDRESS <u>Funeral Home</u> <u>4308 Suitland Road, Suitland, Maryland</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 2 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

1938

JUNE 12, 1904

House

Section

MISSISSIPPI KENNY

WILLIAM L. BERRY

JAMES H. BERRY

NO

MISSISSIPPI KENNY
JAMES H. BERRY
WILLIAM L. BERRY
JUNE 12, 1904
House
Section
1938

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09962

09964

FOR STATE HEALTH DEPT.

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District Of Columbia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | d. STREET ADDRESS 1148 Morse St., N.E. | |
| 3. NAME OF DECEASED (Type or print) First Leon Middle James Last Duncan | | 4. DATE OF DEATH Month 7 Day 29 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 2-10-1919 |
| 9. AGE (In years lost birthday) 48 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME Rhoda ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Rhoda Duncan - 1148 Morse Street, N.E. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Avulsion of brain 812.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car. | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:10am p.m. 7-29- 19 67 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 210, south of Rt. 324, Oxon Hill, Md. | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>John Kehoe</i> | | 22. DATE SIGNED 7-30-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 8-3-1967 | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY Lincoln | | 23d. LOCATION (City or Town) (County) (State) SUITLAND MARYLAND | |
| 24. FUNERAL DIRECTOR W. ERNEST LARVIS CO. | | 25a. REC'D BY REGISTRAR AUG 7 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | 25c. REGISTRAR'S NAME | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

Department of Chemistry
Chicago, Illinois

Mr. J. H. Jones
100 North Dearborn Street
Chicago, Illinois

Dear Mr. Jones:

Enclosed

find a check for \$100.00

Yours very truly,

Robert H. Jones

Enclosed for Mr. Jones, 100 North Dearborn Street, Chicago, Illinois

Very truly yours,

Robert H. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09965

Item #9 Film #G391 7/26/67 ph

09965

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b Washington, D. C. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 817 20th St., N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Mary C. Duncan First Middle Last 4. DATE OF DEATH July 17, 1967 Month Day Year | | 5. SEX F 6. COLOR OR RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 5/27/84 9. AGE (In years last birthday) 84 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired 10b. KIND OF BUSINESS OR INDUSTRY unknown 11. BIRTHPLACE (County & State, or foreign country) N.C. 12. CITIZEN OF WHAT COUNTRY? USA | | 9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min. | |
| 13. FATHER'S NAME Robert Cobbs 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. 277-30-0047 17. INFORMANT decedent Address | | 14. MOTHER'S MAIDEN NAME Mary Blast | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right leg thrombophlebitis DUE TO (c) Generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pyelonephritis with renal insufficiency | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/7/67 , 19 67 , to 7/17/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/17/1967 , and that death occurred at 10:45 PM on causes and on the date stated above. | |
| 22a. SIGNATURE Moe Weiss 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | 22b. DATE SIGNED 7/17/67 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7/21/67 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial 23d. LOCATION (City or Town) (County) (State) Maryland | | 25a. REC'D BY REGISTRAR Jul 21 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | |

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N.Y.

Prince Georges

Glenn Dale (Mrs.)

Washington, D. C.

Glenn Dale Hospital

317 30th St., N.E.

Mary

Herman

July 1, 1947

Relieved

Unknown

N.C.

Robert Gibbs

Mary Gibbs

317-30-447

Decided

Glenn Dale Hospital

Glenn Dale Hospital

Glenn Dale Hospital

Glenn Dale Hospital

July 1, 1947

10:45 AM

317-30-447

N

Glenn Dale Hospital, Glenn Dale, Md.

Not Listed, N.D.

Glenn Dale

July 1, 1947

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09966

| | | | | | | | |
|---|---------------------------|---|--------------------------------------|---|---|---|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> | | | | c. LENGTH OF STAY IN AB <u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Heights 16-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u> | | | | d. STREET ADDRESS <u>5116 S Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>HARRY W EDELEN</u> | | | | 4. DATE OF DEATH <u>July 12 1967</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV. 7, 1885</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 MRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fireman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JOHN EDELEN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY BRADY</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>578-38-057</u> | | 17. INFORMANT <u>PATRICIA A. SMITH BANEAS #2</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>GENERAL ARTERIAL & CORONARY SCLEROSIS</u> DUE TO (c) <u>BRONCHO PNEUMONIA</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>YEARS</u> <u>YRS.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Dayton O Watkins</u> | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 7-12-67 | |
| EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 5318 annapolis | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED | |
| | | | | Address (Street, city, town, or county) <u>Bladensburg Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>7/15/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u> | | 23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD.</u> | |
| 24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO. 517 N. ST. S.E. WASH. D.C.</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 17 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09965

CERTIFICATE OF DEATH

09967

| | | | | | | | |
|---|----------------------------------|--|-------------------------------------|---|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Unknown b. COUNTY DC. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c. LENGTH OF STAY IN 1b. 2 years and 137 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | | | d. STREET ADDRESS Unknown | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle Eubanks Last Eubanks | | | | 4. DATE OF DEATH Month July Day 18 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/7/1879 | 9. AGE (In years lost birthday) 88 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY - - - | | 11. BIRTHPLACE (County & State, or foreign country) Unknown | | 12. CITIZEN OF WHAT COUNTRY? ? | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 213-56-1724 | | 17. INFORMANT (Decedent) D. C. General Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism (clinical) 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis, left leg DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH sudden unknown unknown | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-3 , 19 65 , to 7-18 , 19 67 , that (he) last saw the deceased alive on 7/18 , 19 67 , and that death occurred at 3:45 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Moe Weiss | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 7-18-67 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE THEREOF 7/27/67 | | 23c. NAME OF CEMETERY OR CREMATORY ANATOMICAL BOARD | | 23d. LOCATION (City or town) (County) (State) Washington, D.C. | |
| 24. FUNERAL DIRECTOR Carl F. Aufrecht | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE JUL 28 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles J. Jones | | | |

recovered

Washington, D. C.

Glenn Dale Hospital
Glenn Dale, Maryland

Joe Nelson, M.D.

DATE

7-1

7-1

7-1

67

7-1-67

Generalized myoclonic convulsions

Thrombocytopenia, left leg

Massive pulmonary embolism (clinical)

Unknown

313-24-1710

(Glenn Dale) D. C. General Hospital

Unknown

Unknown

Unknown

Unknown

Male

Height

Weight

86

Chronic

Unknown

July

13

Glenn Dale Hospital

Unknown

Glenn Dale (usual)

10 years and
10 years

Unknown

Unknown

Prince George

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09966

CERTIFICATE OF DEATH

09968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 2 yrs 3 mos. 27 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY 473 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS Germantown Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Elmer Middle Everson Last July | | 4. DATE OF DEATH Month July Day 7 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/9/1882 |
| 9. AGE (In years last birthday) 84 | | 10. IF UNDER 1 YEAR Months 8 Days 4 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown | | 10b. KIND OF BUSINESS OR INDUSTRY unknown | |
| 11. BIRTHPLACE (County & State, or foreign country) unknown | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME unknown | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Decedent | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the prostate with wide metastases 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 8 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/10/19 65 , to 7/7/19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/7/19 67 , and that death occurred at 4:50A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Moe Weiss | | 22b. DATE SIGNED 7/7/67 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 7-10-67 | 23c. NAME OF CEMETERY OR CREMATORY Brownstown Cemetery | 23d. LOCATION (City or Town) (County) (State) Germantown, Mont., Md |
| 24. FUNERAL DIRECTOR George R. Snowden Rockville, Md. | | 25a. REC'D BY REGISTRAR JUL 12 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

520

1999) and also in the case of the *Chrysomelidae* (Graham 1999).

Original also supplied

Chen et al.

[illegible]

2300.

100

558

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09967

CERTIFICATE OF DEATH

09969

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY in 1b 5 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 7113 Rolling Ridge Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Elizabeth Middle C. Last Eyler | | | | 4. DATE OF DEATH Month July Day 25 Year 1967 | | | |
| 5. SEX Female | 6. COLOR OR RACE Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-21-21 | | 9. AGE (In years last birthday) 45 yrs. | IF UNDER 1 YEAR Months 16 Days 1 | IF UNDER 24 HRS. Hours 67 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Edward Phillips | | | | 14. MOTHER'S MAIDEN NAME Mattie Massey | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mary E. Myers (Sister) Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nutritional Cirrhosis of Liver with Hepatic Failure 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this person) attended the deceased from July 20 , 19 67 , to July 25 , 19 67 , that (I) (we) last saw the deceased alive on July 25 , 19 67 , and that death occurred at 10:25P , M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Oliver B. Bond | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 7-26-67 | |
| 22c. PHYSICIAN'S NAME (Type) Oliver B. Bond, M. D. | | | | 22d. ADDRESS 6872 Riverdale Rd. Lanham, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/28/67 | | 23c. NAME OF CEMETERY OR CREMATORY Washington National | | 23d. LOCATION (City or Town) (County) (State) Suitland, Md. | |
| 24. FUNERAL DIRECTOR LEE FUNERAL HOME 3004 ST NE | | | | 25. REC'D BY REGISTRAR JUL 31 1967 | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |

100-10000

REPORT OF DEATH

Decedent's Name: [Illegible]

Place of Birth: [Illegible]

Sex: [Illegible]

Age: [Illegible]

Occupation: [Illegible]

Place of Death: [Illegible]

Cause of Death: [Illegible]

Date: [Illegible]

Signature: [Illegible]

Time: [Illegible]

Place: [Illegible]

Medical History: [Illegible]

History of Present Illness: [Illegible]

Mary J. [Illegible] (Spouse)

Particulars of Cause of Death: [Illegible]

Time of Death: [Illegible]

Signature: [Illegible]

Date: [Illegible]

Age: [Illegible]

Place of Death: [Illegible]

Signature: [Illegible]

Signature: [Illegible]

Date: [Illegible]

12 1

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 be retained by the hospital or attending physician.

ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|---|--|---|
| 09968 | | 09970 | |
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u> | |
| c. LENGTH OF STAY IN TB <u>12 years</u> | | d. STREET ADDRESS <u>5208 Westfield Drive</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5208 Westfield Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>John Francis Fanning, Sr</u> | | 4. DATE OF DEATH <u>July 7</u> 19 <u>67</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 6, 1910</u> |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | 10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Promotion Man</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>News Co</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Takoma Park, Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Wm. Fanning</u> | | 14. MOTHER'S MAIDEN NAME <u>Nora May Grimes</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>WW 2 April 21-1942 (SS) 577-12-4586</u> | |
| 17. INFORMANT <u>Elisabeth Fanning</u> | | Address <u>5208 Westfield Drive</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial Infarction</u> (c) <u>Congestive Heart Failure</u> DUE TO cause last. 5 months | | INTERVAL BETWEEN ONSET AND DEATH <u>1958</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 22, 1967</u> to <u>July 7, 1967</u> that (I) (we) last saw the deceased alive on <u>July 6, 1967</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Anna C. Todd, M.D.</u> M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>ANNA C. TODD, M.D.</u> | | 22d. ADDRESS <u>7519 Broadview Rd. Friendly, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>7-10-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> | | 25a. REC'D BY REGISTRAR <u>JUL 10 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u> | | | |

RECEIVED
FEB 10 1967
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

1-10-67
FEB 10 1967
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09969

09971

| | | | | | | | |
|---|----------------------------------|---|-------------------------------------|--|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro | | | | c. LENGTH OF STAY IN 1b 5 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's County Jail | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Bernard Middle LEO Last Fitzgerald | | | | 4. DATE OF DEATH Month 7 Day 25 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 8-1-1926 | 9. AGE (In years lost birthday) 40 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 24 HRS. Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME MICHAEL J. FITZGERALD | | | | 14. MOTHER'S MAIDEN NAME MARY C YOUNG | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. II | | | | 16. SOCIAL SECURITY NO. 579248333 | | 17. INFORMANT MICHAEL J. FITZGERALD Address 4708 HAMILTON ST, HYATTSVILLE, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Delerium tremens 307X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | | | 22. DATE SIGNED 7-26-67 | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF JULY 29 1967 | | 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM | | 23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C. | |
| 24. FUNERAL DIRECTOR W.W. CHAMBERS CO RIVERDALE, MD | | | | 25a. REC'D BY REGISTRAR AUG 1 1967 | | 25b. REGISTRAR'S SIGNATURE Charles J. Jones | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09970

CERTIFICATE OF DEATH

09972

| | | | | | | | |
|--|---|--|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | | c. LENGTH OF STAY IN 1b 15 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | | | d. STREET ADDRESS 4519 Tuckerman Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Walter Middle B Last Ford | | | | 4. DATE OF DEATH Month 7 Day 30 Year 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/1/97 | | 9. AGE (In years last birthday) 70 yrs. | IF UNDER 1 YEAR Months 7 Days 30 Hours 19 Min. 67 | IF UNDER 24 HRS. Hours 19 Min. 67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) telegrapher | | | 10b. KIND OF BUSINESS OR INDUSTRY A T&T | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? US |
| 13. FATHER'S NAME Frederick K Ford | | | | 14. MOTHER'S MAIDEN NAME Sara R. Shafer | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes, 1917 to 1919 | | | 16. SOCIAL SECURITY NO. 577-07-6678 | | 17. INFORMANT Helen I. Ford Address Riverdale, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ATHEROSCLEROSIS DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS UNKNOWN | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-14</u>, 19<u>62</u>, to <u>7-30</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>7-29</u>, 19<u>67</u>, and that death occurred at <u>7:30</u> AM, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE C. J. Houmann | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 7-30-67 | |
| 22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug 2, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR AUG 2 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Prince George's

England

Prince George's

Riverdale

Is. 6/1/77

Riverdale

451. Rochester street

Island official hospital

67

20

7

ford

D

Walter

White

70

6/1/77

U

England

A. T. H.

telegrapher

271-7-6670

271-7-6670

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09971

CERTIFICATE OF DEATH

09973

| | | | | | | | |
|---|------------------------------|---|-----------------------------------|---|---------------------------|---|---------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> | | | | c. LENGTH OF STAY IN 1b <u>4 DAYS</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u> | | | | 161 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINE VIEW GARDENS</u> | | | | d. STREET ADDRESS <u>21 DEVOL STREET</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>GARLICK</u> Last <u>GARLICK</u> | | | | 4. DATE OF DEATH Month <u>7</u> Day <u>5</u> Year <u>1967</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/8/80</u> | 9. AGE (In years last birthday) <u>87</u> yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 24 HRS. Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COAL MINER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>COAL</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JOSEPH GARLICK</u> | | | | 14. MOTHER'S MAIDEN NAME <u>EVA PRICE</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>1221</u> | | 17. INFORMANT <u>MARGARET GARLICK SAME AS #2</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO <u>ISCUE - complicated CHF</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/2</u> , 19 <u>67</u> , to <u>7/5</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7/4</u> , 19 <u>67</u> and that death occurred at <u>5:41</u> A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Robert E. Wellchlin</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>7/5/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert E. Wellchlin</u> | | | | 22d. ADDRESS <u>4308 Suitland Rd Suitland Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 8, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cook Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Wellersburg Pa.</u> | |
| 24. FUNERAL DIRECTOR <u>Robert E. Wellchlin</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 7 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. J. Jones</u> | |

THE RECORD OF DEATH

1910

1910

1. Name of deceased
2. Age
3. Sex
4. Race
5. Date of death
6. Place of death
7. Cause of death
8. Signature of physician
9. Signature of registrar
10. Date of registration

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I Talked by phone with coroner of Prince Georges County, Md. and he said I may sign death certificate.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09972

09974

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOSPITAL BOX 82 RT. # 4 | | | | d. STREET ADDRESS HOSPITAL BOX 82 RT. # 4 | | | |
| 3. NAME OF DECEASED (Type or print) MYRTELLE GORDON GEMENY | | | | 4. DATE OF DEATH Month JULY Day 23 Year 19 67 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 13, 1896 | | 9. AGE (In years last birthday) 71 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WILLIAM W. GORDON | | | | 14. MOTHER'S MAIDEN NAME MARY E. MAYES | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address ANDREW GEMENY SAME AS # 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden 5+yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from February, 1965 , to July 23, 1967 , that (I) (we) last saw the deceased alive on November 20, 1966 , and that death occurred at 7 A.M. , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE John F. Gustafson | | | | 22b. DATE SIGNED July 24, 1967 | | 22c. PHYSICIAN'S NAME (Type) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7/26/67 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | | 23d. LOCATION (City or Town) (County) (State) SUITLAND, PRINCE GEORGES, Md. | |
| 24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND | | | | 25a. REC'D BY REGISTRAR DATE JUL 27 1967 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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DEPARTMENT OF HEALTH

UNITED STATES

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**AK amputation, right, 6/64

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09973

CERTIFICATE OF DEATH

09975

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c. LENGTH OF STAY IN 1b 3 wks., 2 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Benjamin Middle H. Last Gibson | | 4. DATE OF DEATH Month 7 Day 22 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/22/1892 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown - retired | | 10b. KIND OF BUSINESS OR INDUSTRY -- | |
| 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Allen Gibson | | 14. MOTHER'S MAIDEN NAME Elizabeth Pyer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes unknown | | 16. SOCIAL SECURITY NO. 577-12-3521 | |
| 17. INFORMANT Decedent | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia (10 days) and adrenal insufficiency DUE TO (b) Urinary tract infection DUE TO (c) Pulmonary tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| INTERVAL BETWEEN ONSET AND DEATH unknown 4 yr. 9 mo. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (c) Generalized arteriosclerosis with arteriosclerotic heart disease and peripheral vascular insufficiency; BK amputation, left, 6/62; ** | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/29/ , 19 67 , to 7/22 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/22/ 19 67 , and that death occurred at 4:00 P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Moe Weiss | | 22b. DATE SIGNED 7/22/67 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 7/26/67 | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City or town) (County) (State) Virginia | |
| 24. FUNERAL DIRECTOR Malvan & Schey, Inc. | | 25a. REC'D BY REGISTRAR DATE JUL 26 1967 | |
| 25b. REGISTRAR'S SIGNATURE g. m. jones | | | |

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Glenn Dale Hospital
Glenn Dale, Md.

Has veins, M. P.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville 16-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | d. STREET ADDRESS 11427 Cherry Hill Road | |
| 3. NAME OF DECEASED (Type or print) First Middle Last James Henry Golden | | 4. DATE OF DEATH Month Day Year 7 21 1967 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-3-40 |
| 9. AGE (In years last birthday) 26 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apprentice Engineer Crane Rental Co. Florida | | 10b. KIND OF BUSINESS OR INDUSTRY Florida | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Sam H. Golden | | 14. MOTHER'S MAIDEN NAME Alice Driskoll | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Act. Reserve | | 16. SOCIAL SECURITY NO. 267-56-0993 | |
| 17. INFORMANT Sally H. Golden Same as # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary edema 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) multiple fractures, contusions & lacerations DUE TO (c) trauma - auto accident | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) driver of car involved in collision | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8:30pm 7-19 19 67 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 10000 block, Cherry Hill Rd., Beltsville, Md., PG | | 20f. (City or town) (County) (State) Beltsville, Md., PG | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7-26-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cottondale Cemetery | | 23d. LOCATION (City or Town) (County) (State) Cottondale, Florida | |
| 24. FUNERAL DIRECTOR Lee Funeral Home 300 4th St. NE Wash.D.C. | | 25a. REC'D BY REGISTRAR JUL 25 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | 22. DATE SIGNED 7-21-67 | |

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4909 70th PLACE</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u> d. STREET ADDRESS <u>4909 70th PLACE</u> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>IRVING L. GRIGGS</u> | | | | | | 4. DATE OF DEATH <u>JULY 27 1967</u> | | | | | | | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>APR 21 1903</u> | | 9. AGE (In years last birthday) <u>64</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SERVICE STATION</u> | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>IRVING L. GRIGGS</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>LOUISA GREENWOOD</u> | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>579077916A</u> | | 17. INFORMANT <u>BETTIE W. GRIGGS,</u> Address <u>SAME AS #2</u> | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OBSTRUCTIVE PULMONARY EMPHYSEMA</u> 5271 DUE TO (b) <u>5271</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | | | | | |
| 21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>JULY 26, 1967</u> to <u>27 July, 1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>26 July, 1967</u> , and that death occurred at <u>8:10 p.m.</u> from the causes and on the date stated above. | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Thomas G. Maloney</u> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. ADDRESS <u>4814 - 71st AVE., WOODLAWN, MD.</u> | | 22c. DATE SIGNED <u>27 July 67</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>THOMAS G. MALONEY</u> | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 23b. DATE THEREOF <u>JULY 31, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM</u> | | 23d. LOCATION (City, town or county) (State) <u>BLADENSBURG MARYLAND</u> | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS, Co.</u> | | | | | | ADDRESS <u>RIVERDALE, MD</u> | | 25a. REC'D BY REGISTRAR <u>AUG 1 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u> | | | | | | | |

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Sam (del)</u> b. COUNTY <u>Pro. 1200</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5402-38 Ave</u> | | d. STREET ADDRESS <u>5402-38 Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Gertrude Smith Gross</u> | | 4. DATE OF DEATH <u>July 28</u> 19 <u>67</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11 Sept 1894</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Merchandise</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Cumberland Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Henry E. Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Regina Whalley</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>578 26 6299</u> | |
| 17. INFORMANT <u>4077 Longfellow</u> | | Address <u>Hyattsville Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO <u>Hypertensive arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiovascular disease</u> DUE TO (c) <u>cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1945</u> , 19 <u>67</u> , to <u>28 July</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>27 July</u> , 19 <u>67</u> , and that death occurred at <u>8:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2200 R. 9 Ave N.E. Wash. D.C.</u> DATE SIGNED <u>28 July 67</u> | | | |
| ACTUAL SIGNATURE <u>Thomas E. Mattingly, M.D.</u> | | PHYSICIAN'S NAME (Type) <u>Thomas E. Mattingly</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Aug 1, 1967</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Pro Geo Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> | | ADDRESS <u>Hyattsville, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>AUG 1 1967</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| NAME OF DECEASED <i>John Doe</i> | | AGE <i>45</i> | | SEX <i>Male</i> | | RACE <i>White</i> | | DATE OF BIRTH <i>Jan 1, 1925</i> | | PLACE OF BIRTH <i>Baltimore, Md.</i> | |
| MARRIED <i>Yes</i> | | OCCUPATION <i>Teacher</i> | | EDUCATION <i>High School</i> | | RELIGION <i>Catholic</i> | | MANNER OF DEATH <i>Natural</i> | | CAUSE OF DEATH <i>Heart Disease</i> | |
| DATE OF DEATH <i>Dec 15, 1970</i> | | PLACE OF DEATH <i>Home</i> | | TIME OF DEATH <i>10:00 AM</i> | | TEMPERATURE <i>Normal</i> | | PULSE <i>Normal</i> | | RESPIRATION <i>Normal</i> | |
| SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i> | | SIGNATURE OF WITNESS <i>John Doe</i> | | SIGNATURE OF DECEASED <i>John Doe</i> | | SIGNATURE OF NEAREST RELATIVE <i>John Doe</i> | | SIGNATURE OF CLERK <i>John Doe</i> | | SIGNATURE OF REGISTRAR <i>John Doe</i> | |
| DATE OF SIGNATURE <i>Dec 15, 1970</i> | | DATE OF SIGNATURE <i>Dec 15, 1970</i> | | DATE OF SIGNATURE <i>Dec 15, 1970</i> | | DATE OF SIGNATURE <i>Dec 15, 1970</i> | | DATE OF SIGNATURE <i>Dec 15, 1970</i> | | DATE OF SIGNATURE <i>Dec 15, 1970</i> | |

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during the last illness.

2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person.

3. The manner of death should be stated as natural, accidental, or homicidal.

4. The date of death should be stated in full, including the day, month, and year.

5. The place of death should be stated in full, including the street, city, county, and state.

6. The time of death should be stated in full, including the hour, minute, and second.

7. The temperature, pulse, and respiration should be stated in full, including the rate and character.

8. The signature of the physician or other qualified person should be written in full, including the name and title.

9. The signature of the witness should be written in full, including the name and address.

10. The signature of the deceased should be written in full, including the name and address.

11. The signature of the nearest relative should be written in full, including the name and address.

12. The signature of the clerk should be written in full, including the name and address.

13. The signature of the registrar should be written in full, including the name and address.

14. The date of signature should be written in full, including the day, month, and year.

15. The date of death should be written in full, including the day, month, and year.

16. The date of birth should be written in full, including the day, month, and year.

17. The date of marriage should be written in full, including the day, month, and year.

18. The date of occupation should be written in full, including the day, month, and year.

19. The date of education should be written in full, including the day, month, and year.

20. The date of religion should be written in full, including the day, month, and year.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ o. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 8 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | d. STREET ADDRESS 4903 77th Place | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Vincent Middle G. Last Hahn | | | 4. DATE OF DEATH Month July Day 28 Year 1967 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/9/04 | 9. AGE (In years last birthday) 63 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal worker | | 10b. KIND OF BUSINESS OR INDUSTRY construction | | 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | |
| 13. FATHER'S NAME John Hahn | | | 14. MOTHER'S MAIDEN NAME Mary Kuntz | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 210 10 2005 | | 17. INFORMANT John Hahn Address New Carrollton Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Uremia DUE TO (b) Ruptured aortic aneurysm DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 8 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7/20/67 , 19 67 , to July 28 , 19 67 , that (I) (we) last saw the deceased alive on 7/28 19 67 , and that death occurred at 5:00 PM from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE F. E. Musser, MD | | | 22b. DATE SIGNED 7/28/67 | | 22c. PHYSICIAN'S NAME (Type) F. E. Musser, MD |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug 1, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | | ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR AUG 1 1967 |
| | | | 25b. REGISTRAR'S SIGNATURE Charles J. J... | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09978

09930

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Princes Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, Dist. of Columbia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base | | c. LENGTH OF STAY IN TB 1 Day | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews | | d. STREET ADDRESS 220 Savannah Street | |
| 3. NAME OF DECEASED (Type or print) First SHELIA Middle ODETTE Last HALL | | 4. DATE OF DEATH Month July Day 10 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE Neg | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9 July 1967 |
| 9. AGE (In years last birthday) yrs. 1 | | IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA | | 10b. KIND OF BUSINESS OR INDUSTRY NA | |
| 11. BIRTHPLACE (County & State, or foreign country) Prince Georges, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Richard Jerome Hall | | 14. MOTHER'S MAIDEN NAME Marvell Elizabeth Tolson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Father-same as item #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Respiratory Failure DUE TO (c) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9 July , 1967, to 10 July , 1967, that we last saw the deceased alive on 10 July , 1967, and that death occurred at 3:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Arnold A. Abramo</i> | | 22b. DATE SIGNED 10 July 1967 | |
| 22c. PHYSICIAN'S NAME (Type) ARNOLD A ABRAMO, LCOL, USAF, MC USAFH Andrews, Andrews AFB, Md. | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 7-17-67 | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL CEM | 23d. LOCATION (City or Town) (County) (State) FT MYER VA |
| 24. FUNERAL DIRECTOR <i>W.W. Chambers Co</i> | | 25a. REC'D BY REGISTRAR JUL 17 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | DATE | |

Washington, Dist. of Columbia

Washington DC

320 Savannah Street

July 10 67

8 July 1967

Prince Georges, Md. USA

Harvett Elizabeth Tolson

Father-son as item 33

Corbin Talbot

Respiratory Failure

Pneumonia

Prince Georges

Andrew Air Force Base

USAF Hospital Andrews

SHIRAZ

ODETTE

Female Neg

NA

NA

Richard Jerome Hall

None

NA

NO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

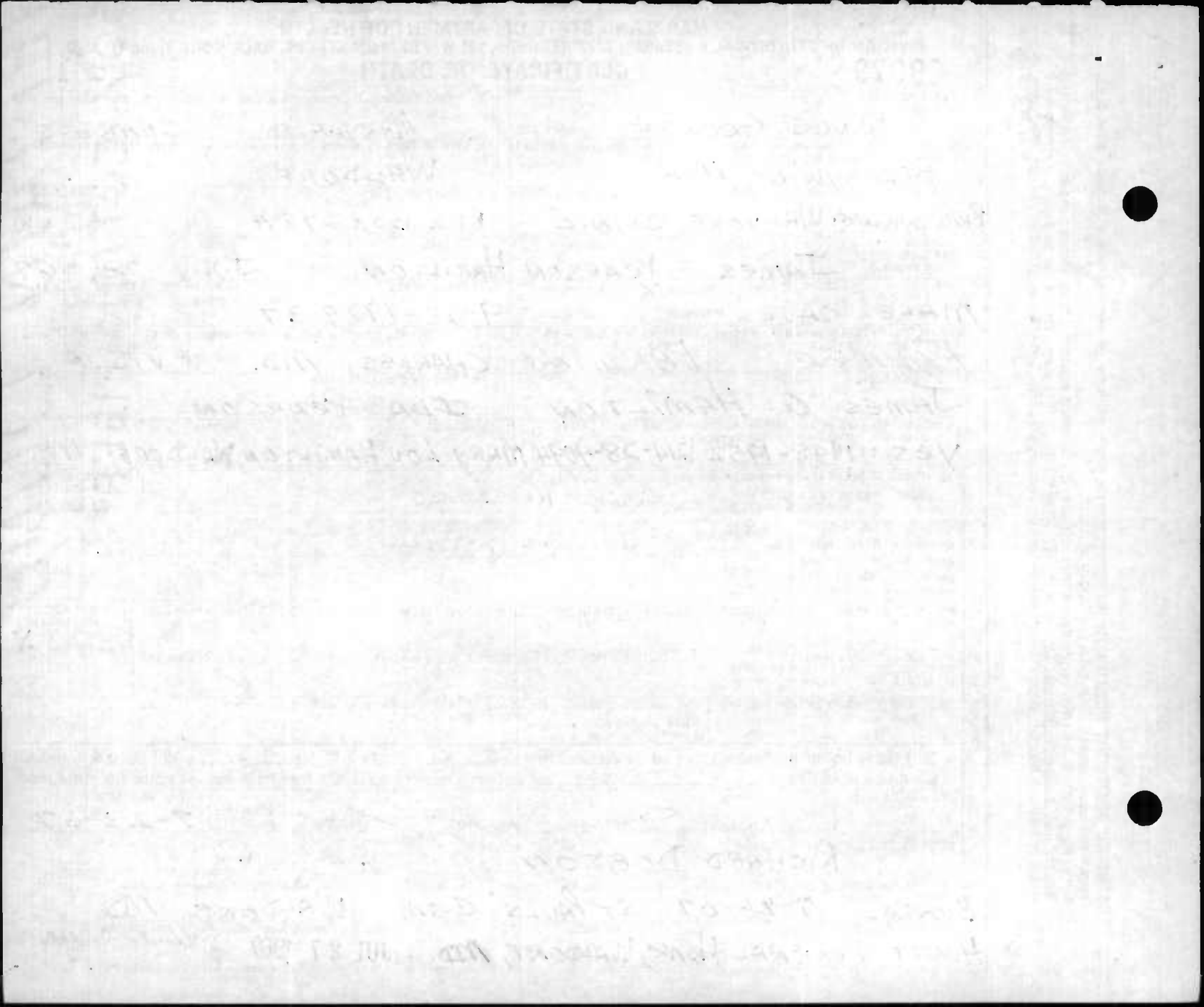
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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099981

| | | | |
|--|---|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE MD.</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BRANDYWINE-WALDORF CLINIC</u> | | d. STREET ADDRESS <u>RT 2 BOX 278A</u> | |
| 3. NAME OF DECEASED (Type or print) <u>JAMES PEARSON HAMILTON</u> | | 4. DATE OF DEATH Month <u>JULY</u> Day <u>23</u> Year <u>1967</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>CAU.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-23-1929</u> |
| 9. AGE (in years last birthday) <u>37</u> yrs. | | 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>CHARLES, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JAMES O. HAMILTON</u> | | 14. MOTHER'S MAIDEN NAME <u>IDA PEARSON</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>214-28-4094</u> | |
| 17. INFORMANT <u>MARY LOU HAMILTON</u> | | Address <u>WALDORF, MD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Brain</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>yes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-20</u> , 19 <u>58</u> , to <u>7-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-23</u> , 19 <u>67</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Richard Dobson</u> | | 22b. DATE SIGNED <u>7-23-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>RICHARD DOBSON</u> | | 22d. ADDRESS <u>Brandywine, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>7-26-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>ST PAULS CEM.</u> | | 23d. LOCATION (City, town or county) (State) <u>WALDORF, MD.</u> | |
| 24. FUNERAL DIRECTOR <u>HUNTT FUNERAL HOME, WALDORF, MD.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 27 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1d Film #G390 7/6/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09980

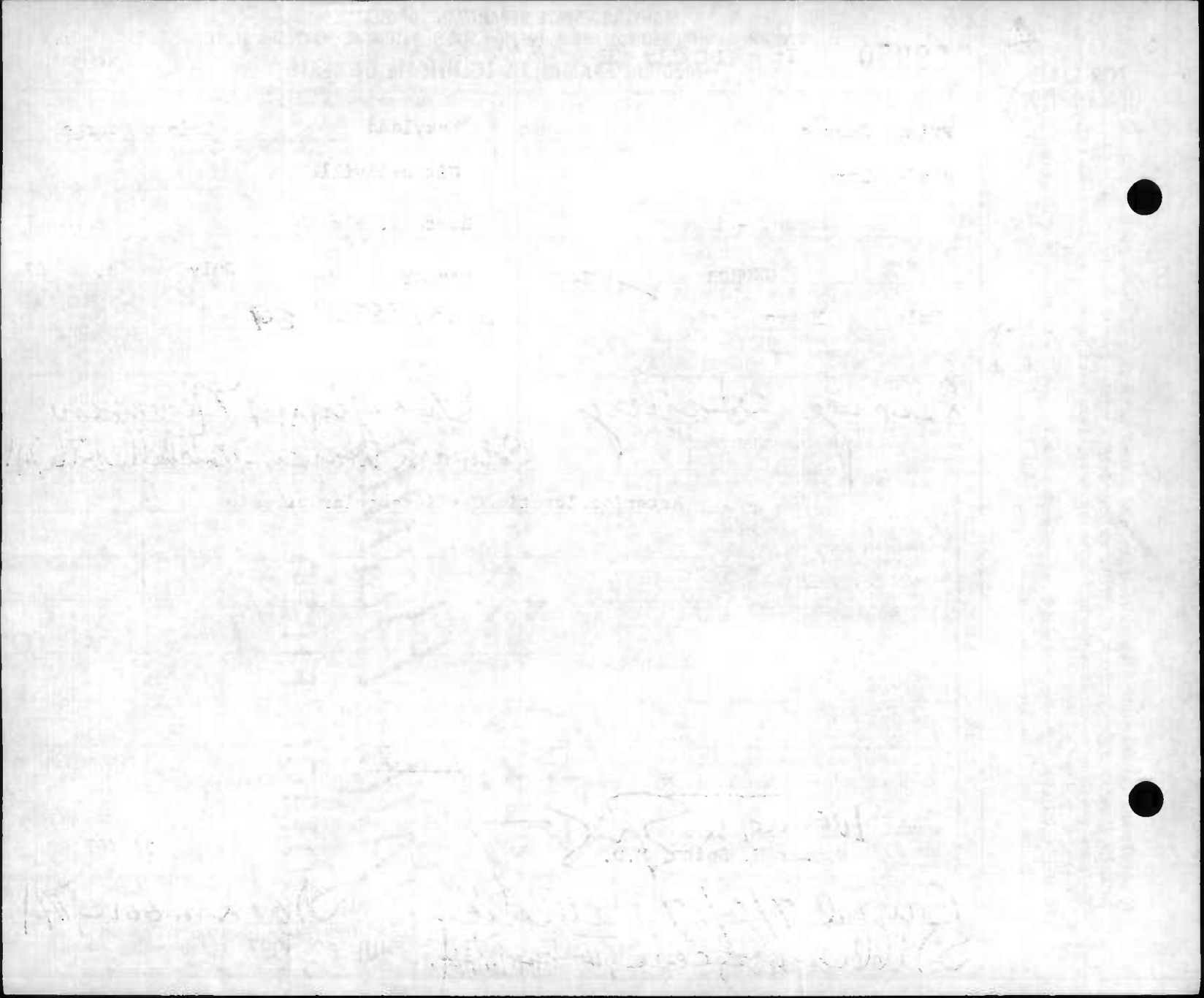
09982

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|--|---|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Found on Street - in car | | | | d. STREET ADDRESS Route 2, Box 80 | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 16.1 | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GEORGE NELSON HARLEY | | | | 4. DATE OF DEATH Month Day Year July 3, 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/15/1898 | 9. AGE (In years last birthday) yrs. 69 | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME George Harley | | | | 14. MOTHER'S MAIDEN NAME Georgiana Newman | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Edward Harley - Mitchellville | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz | | EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) | | 22. DATE SIGNED 7/4/67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 7/6/67 | | 23c. NAME OF CEMETERY OR CREMATORY Catholic | | 23d. LOCATION (City or town) (County) (State) Stoodmoore, Md. | |
| 24. FUNERAL DIRECTOR William Geese, H. Lang, Md. | | | | 25a. REC'D BY REGISTRAR DATE JUL 5 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|------------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b DOA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Thomas Middle Harris, Jr. Last Harris, Jr. | | | | 4. DATE OF DEATH Month 7 Day 30 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 1 Nov. 1903 | 9. AGE (In years lost birthday) yrs. 63 | IF UNDER 1 YEAR Months 7 Days 30 Hours 19 Min. 67 | | IF UNDER 24 HRS. Hours 19 Min. 67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Management Consultant | | | 10b. KIND OF BUSINESS OR INDUSTRY Management Consultant | | 11. BIRTHPLACE (State or foreign country) Texas | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Thomas Harris | | | 14. MOTHER'S MAIDEN NAME Mae C. -- | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 454-03-6732 | | 17. INFORMANT David N. Harris Son 1051 N Manchester | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus - over 13 yrs. Metastatic carcinoma (colon) - 1 yr. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes unknown |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | | 22. DATE SIGNED 7-31-67 | | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | | Address (Street, city, town, or county) Riverdale, Md. | | | | |
| 23a. BURIAL CREMATION Burial | 23b. DATE THEREOF 8/2/67 | 23c. NAME OF CEMETERY OR CREMATORY Rockville | | 23d. LOCATION (City or Town) (County) (State) Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home | | | | 25. REC'D BY REGISTRAR AUG 2 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09982

CERTIFICATE OF DEATH

09984

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base | | c. LENGTH OF STAY IN TB DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last HARVEY | | 4. DATE OF DEATH Month July Day 7 Year 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8 May 1939 |
| 9. AGE (In years last birthday) 28 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY NA | 11. BIRTHPLACE (County & State, or foreign country) Mass. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Charles James Flagg | |
| 14. MOTHER'S MAIDEN NAME Mary Bergin | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No NA | |
| 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT Husband-same as item #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLY CARDIAC ARREST DUE TO 7545 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SECONDARY TO CONGENITAL HEART BLOCK DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that XX (this hospital) attended the deceased from January , 19 67 , to 7 July , 19 67 , that (X) (we) last saw the deceased alive on 7 July , 1967, and that death occurred at 435 p.m. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Walter Myalls | | 22b. DATE SIGNED 7 July 1967 | |
| 22c. PHYSICIAN'S NAME (Type) WALTER MYALLS, CAPT, USAF, MC | | 22d. ADDRESS USAF Hosp, Andrews AFB, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 7/11/67 | 23c. NAME OF CEMETERY OR CREMATORY ST. ROCKS | 23d. LOCATION (City or Town) (County) (State) WORCESTER, MASS. |
| 24. FUNERAL DIRECTOR W W CHAMBERS CO., INC. | | 25a. REC'D BY REGISTRAR 514 11TH ST. S.E. WASH. D.C. | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE JUL 12 1967 | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G391 8/2/67 db

09983

CERTIFICATE OF DEATH

09985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> c. LENGTH OF STAY IN 1b <u>7/5/67</u> to <u>7/14/67</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland Hosp</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PG Co</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> d. STREET ADDRESS <u>Lusby LA</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Hawkins, Patrick E</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-19-95</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. | | | | 4. DATE OF DEATH <u>7-14-67</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Clarence E. Hawkins</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Harriet A. Byson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>215-46-4620</u> | | 17. INFORMANT <u>Mrs. Thomasine Young</u> Address <u>Lusby Lane, Brandywine, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO (b) <u>Carcinomatous</u> DUE TO (c) <u>Carcinoma Esophagae</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>9-4 hrs</u> <u>3 wks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-5-67</u> to <u>7-14-67</u> , that (I) (we) last saw the deceased alive on <u>7-14-67</u> , and that death occurred at <u>9:50 AM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Alfred R. Lapin, M.D.</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, MD.</u> | | | | 22d. ADDRESS <u>CLINTON, MD.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 19/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Union Bethel Ch. Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Brandywine PG Co Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Martell Adams Aquasco, Md.</u> ADDRESS | | | | 25a. REC'D BY REGISTRAR <u>JUL 21 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

CONFIDENTIAL - SECURITY INFORMATION

(Faint handwritten notes at the bottom of the page)

5 M

James L. Hall

1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|-------------------------|---|---|---|---|---|---|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 09984 CERTIFICATE OF DEATH 09986 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>D.C.</u> b. COUNTY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>173</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Manor</u> | | | | | d. STREET ADDRESS <u>2860 - 28 th St. N.W.</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First <u>MARY</u> | | Middle <u>CLARK</u> | | Last <u>HAYDEN</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>19 67</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug. 25, 1885</u> | | 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles H. Clark</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary J. Hines</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>***** 577-48-7081</u> | | 17. INFORMANT <u>Joseph Hayden</u> | | Address <u>3000 - 39th St. NW</u> | | <u>Wash. D.C.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolus</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 15</u> , <u>1966</u> , to <u>Jul. 13</u> , <u>1967</u> , that (I) (we) last saw the deceased alive on <u>Jul. 12</u> , <u>1967</u> , and that death occurred at <u>3: P</u> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Thomas F. Collins</u> | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>7/13/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Thomas F. Collins</u> | | | | | 22d. ADDRESS <u>322 H ST. N.E. Wash. D.C.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 17, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u> | | 23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> | | | | | ADDRESS <u>Washington, D.C.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 20 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09985

09987

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| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY ARLINGTON | |
| b. CITY OR TOWN (If outside corporate limits, and give nearest town) ANDREWS AIR FORCE BASE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | d. STREET ADDRESS 2008 N. JEFFERSON ST. | |
| 3. NAME OF DECEASED (Type or print) ERNEST FRANCIS HEARON JR. | | 4. DATE OF DEATH Month JULY Day 1 Year 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 26 FEBRUARY 1920 |
| 9. AGE (In years last birthday) 47 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAJOR | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE | |
| 11. BIRTHPLACE (County & State, or foreign country) MASSACHUSETTS | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ERNEST FRANCIS HEARON | | 14. MOTHER'S MAIDEN NAME CHRISTINE J. DOYLE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1940-PRESENT | | 16. SOCIAL SECURITY NO. 048-05-2850 | |
| 17. INFORMANT MRS. MARY K. HEARON | | Address SAME AS #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE CARDIAC ARREST 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES 2 DAYS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 29 JUNE , 1967, to 1 JULY , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1 JULY , 1967, and that death occurred at 7:40 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Charles D. Phelps</i> | | 22b. DATE SIGNED 1 JULY 1967 | |
| 22c. PHYSICIAN'S NAME (Type) CHARLES D. PHELPS, CAPT, USAF, MC | | 22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Jul 6, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <i>David James</i> | | 25a. REC'D BY REGISTRAR DATE JUL 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

10088

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09986

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09988

| | | | | | | | |
|--|----------------------------------|---|---------------------------------------|--|---|---|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland 16-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS 3123 Parkway Terr., Apt. 23 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ruth Middle S Last Hine | | | | 4. DATE OF DEATH Month 7 Day 20 Year 1967 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-28-1907 | | 9. AGE (In years last birthday) 59 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager | | 10b. KIND OF BUSINESS OR INDUSTRY Apt. Units | | 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NO | | 17. INFORMANT Willis C. Hine 3123 Parkway Terr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 7-21-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 22, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | 23d. LOCATION (City or Town) (County) (State) Bladensburg Md. | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm 4308 Suitland Rd. Suitland, Md. | | | | 25a. REC'D BY REGISTRAR JUL 25 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09987

09989

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 14 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights d. STREET ADDRESS 606 60th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Hazel C. Hockman | | | | 4. DATE OF DEATH Month Day Year July 12, 1967 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/24/00 | |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (County & State, or foreign country) Washington, D. C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William E. Jenkins | | | | 14. MOTHER'S MAIDEN NAME Sardona Burch | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Elmer L. Hockman Address 606 60th Ave Capitol Hgts | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC ARREST + SHOCK DUE TO (c) PERFORATION OF SURGICAL ANASTOMOSIS OF COLON | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EDEMA; HEMORRHAGIC ASCITES; RENAL INSUFFICIENCY | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (1) the hospital attended the deceased from 1960 , 19 July 12, 1967 , that (1) was last saw the deceased alive on July 12, 1967 , and that death occurred at 6:15 P. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Peter Duus | | | | 22b. DATE SIGNED 7/13/67 | | 22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus | |
| 22d. ADDRESS 6124 Central Ave., Capitol Hgts., Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7-15-1967 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Washington D. C. | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Road Suitland Maryland | | | | 25a. REC'D BY REGISTRAR JUL 18 1967 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

THE NATIONAL ARCHIVES COLLEGE PARK, MARYLAND

RECORDS OF THE

1901

General (General) Maryland Three (Three)

General (General) In (In) Capital (Capital)

General (General) General (General) General (General)

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09988

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09988

| | | | | | | | |
|---|---------------------------|---|-------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Pr George</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> | | | | c. LENGTH OF STAY IN 1b <u>DOA</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u> | | | | e. STREET ADDRESS <u>1206 Quatan St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>OLA (NMN) HUFF</u> | | | | 4. DATE OF DEATH <u>July 3 1967</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 12 1905</u> | 9. AGE (In years last birthday) <u>62</u> Yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Casualty Hospital</u> | | 11. BIRTHPLACE (State or foreign country) <u>Richmond VA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>William Crouch</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Elizabeth Bauffey</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>174X</u> | | | | 17. INFORMANT <u>Louise Pickering</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion + toxemia</u> DUE TO (b) <u>Carcinoma of uterus</u> DUE TO (c) <u>1 year +</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| 22. DATE SIGNED <u>7-3-67</u> | | | | 23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 24. ACTUAL SIGNATURE <u>Dayton O. Watkins</u> M.D. | | | | 25. ADDRESS (Street, city, town, or county) <u>Bladensburg Md.</u> | | | |
| 26. EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS</u> | | | | 27. ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u> | | | |
| 28. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 29. DATE THEREOF <u>July 6, 1967</u> | | | |
| 30. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u> | | | | 31. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u> | | | |
| 32. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> | | | | 33. ADDRESS <u>Hyattsville, Md.</u> | | | |
| 34. REC'D BY REGISTRAR <u>JUL 6 1967</u> | | | | 35. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELETED</u> b. COUNTY <u>47.3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> | c. LENGTH OF STAY IN 1b <u>2 mo.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suitland Nursing Home</u> | | d. STREET ADDRESS <u>208 Mass Ave N.E.</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>MARK</u> Last <u>HUTTON</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>19 67</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 5, 1888</u> |
| 9. AGE (In years last birthday) <u>79 yrs.</u> | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>12</u> Min. <u>19</u> | 11. IF UNDER 24 HRS. Months <u>7</u> Days <u>9</u> Hours <u>12</u> Min. <u>19</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gen'l - Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>England</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>David Hall</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Brown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>579-44-2821</u> | 17. INFORMANT <u>Mrs. Mary L. Chodwick. RIGGS NAT. BANK.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction, acute 4 hrs</u> DUE TO (c) <u>Coronary Insufficiency, Arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 26, 19 67</u> , to <u>July 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 12 19 67</u> , and that death occurred at <u>11:30 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>F. Joseph Weber</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>7/12/67</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>F. JOSEPH WEBER</u> | | 22d. ADDRESS <u>3230 Penna. Ave. S.E.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>7/14/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u> |
| 24. FUNERAL DIRECTOR <u>St. Helens Co.</u> | | 25a. REG'D BY REGISTRAR <u>29011401 NW DC</u> | 25b. REGISTRAR'S SIGNATURE <u>JUL 14 1967</u> |

STATEMENT OF FACTS

100-100000

TO THE DIRECTOR

FROM THE SAC

RE: [illegible]

DATE: [illegible]

BY: [illegible]

APPROVED AND FORWARDED:
SPECIAL AGENT IN CHARGE
JUL 1 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G391 7/26/67 kk

CERTIFICATE OF DEATH

09990

09992

| | | | |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY P.G. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN Tb 41 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | 164 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital | | d. STREET ADDRESS 5814 63rd Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Herbert First Felix Middle Jaskowski Last | | 4. DATE OF DEATH 7 Month 16 Day 19 67 Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-14-01 |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Specialist Sound Music | | 10b. KIND OF BUSINESS OR INDUSTRY Germany | |
| 11. BIRTHPLACE (County & State, or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? America | |
| 13. FATHER'S NAME Joseph Jaskowski | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 012 05 7811 | |
| 17. INFORMANT Hospital records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with Metastases DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 5, 1967 to July 16, 1967 , that (I) (we) last saw the deceased alive on July 15, 1967 , and that death occurred at 4:50 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE L W MALIN | | 22b. DATE SIGNED 7/17/67 | |
| 22c. PHYSICIAN'S NAME (Type) L W MALIN M.D. | | 22d. ADDRESS Riverdale, Md. | |
| 23a. MANNER OF DEATH Cremation | | 23b. DATE THEREOF July 17, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory | | 23d. LOCATION (City or Town) (County) (State) Bladensburg, Md. | |
| 24. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md. | | 25a. REC'D BY REGISTRAR JUL 19 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09991

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09993

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any details necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | | |
| c. LENGTH OF STAY IN 1b DOA | | | | d. STREET ADDRESS 6100 42nd. Ave., Apt. C-202 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Luther Middle Elbert Last Johnson | | | | 4. DATE OF DEATH Month 7 Day 27 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6 Oct. 1928 | | 9. AGE (In years last birthday) 38 yrs. | IF UNDER 1 YEAR Months 9 Days 21 | IF UNDER 24 HRS. Hours 21 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) STATE OF VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address MD. MRS. LUTHER JOHNSON (WIFE) HYATTSVILLE, | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 9023 DUE TO Multiple fractures and lacerations Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) Fell from roof at construction site. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 3:50pm 7-27- 19 67 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7005 Goodluck Rd., Prince George Co., Md. | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED 7-28-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/30/1967 | | 23c. NAME OF CEMETERY OR CREMATORY BUCKHANNON COUNTY, VA. | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR Hysong Funeral Home | | ADDRESS 1300-N St. NW | | 25a. REC'D BY REGISTRAR JUL 31 1967 | | 25b. REGISTRAR'S SIGNATURE f Charles J. J... | |
| PER: Thomas M. Hysong | | | | WASHINGTON, DC | | | |

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

MEMORANDUM FOR THE ATTORNEY GENERAL

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09992

CERTIFICATE OF DEATH

09994

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|-------------------------------|---|---------------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 6 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | d. STREET ADDRESS 4910 70th Place | | | |
| 3. NAME OF DECEASED (Type or print) First Samuel Middle A Last Jones | | | | 4. DATE OF DEATH Month July Day 9 Year 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8 Sept., 1893 | 9. AGE (In years last birthday) 73 yrs. | IF UNDER 1 YEAR Months 42 Days 16 | | IF UNDER 24 HRS. Hours 16 Min. 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant | | 10b. KIND OF BUSINESS OR INDUSTRY Eng. Co. | | 11. BIRTHPLACE (County & State, or foreign country) England | | 12. CITIZEN OF WHAT COUNTRY? England | |
| 13. FATHER'S NAME Thomas Jones | | | | 14. MOTHER'S MAIDEN NAME Martha J Haddock | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. xxxx 278-32-0985 | | 17. INFORMANT Address Florrie Jones, Wife Same as #2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent carcinoma, perianapillary region DUE TO (b) Gastric carcinoma DUE TO (c) 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH Two months 42 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) the doctor attended the deceased from 6/24 , 19 67 , to July 9 , 19 67 , that (I) was last saw the deceased alive on July 9 , 19 67 , and that death occurred on 9.25 PM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Frederick Wilhelm | | | | 22b. DATE SIGNED July 10, 1967 | | 22c. PHYSICIAN'S NAME (Type) Frederick Wilhelm, M. D. | |
| 22d. ADDRESS 6319 Landover Rd. Cheverly, Md. | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 13, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | |
| 24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR JUL 13 1967 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09993

Item #2a,b,c & d Film #G391 8/11/67 ph

09995

CERTIFICATE OF DEATH

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Pr. Geo.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Fred.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pineview gardens Health care center Rt. #2</u> | | d. STREET ADDRESS <u>Rt. #2</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARVIN</u> Middle <u>D.</u> Last <u>Julian</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 4, 1877</u> |
| 9. AGE (In years lost birthday) <u>89</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>TENNA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>MARSENA JULIAN</u> | | 14. MOTHER'S MAIDEN NAME <u>ELIZ. WILSON</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>MRS. JULIAN WIFE</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Falling blood pressure</u> <u>4200</u> DUE TO <u>Arterial Sclerotic Heart disease,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart failure</u> (c) <u>Hepatoma?</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/28</u> , 19 <u>67</u> , to <u>7/31</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7/31</u> , 19 <u>67</u> , and that death occurred at <u>6:55 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James M. Johnson</u> | | 22b. DATE SIGNED <u>7/31/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>James M. Johnson</u> | | 22d. ADDRESS <u>Karrick Hall 606 17th St SE Wash DC</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE THEREOF <u>July 31, 67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>GEORGETOWN MEDICAL</u> | 23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u> |
| 24. FUNERAL DIRECTOR <u>Robert A DeCh</u> | | 25. REC'D BY REGISTRAR <u>AUG 3 1967</u> | |
| 25a. ADDRESS <u>Washington DC</u> | | 25b. REGISTRAR'S SIGNATURE <u>James M. Johnson</u> | |

RECEIVED
UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|--|--|
| 09994 | | 09996 | |
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>DC</u> <u>P&V</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <u>16-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>REGENT NURSING HOME</u> | | d. STREET ADDRESS <u>7802 B STREET</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA</u> <u>KARRAU</u> | | 4. DATE OF DEATH Month Day Year <u>July</u> <u>11</u> <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC. 13 1889</u> 77 yrs. |
| 9. AGE (In years last birthday) <u>77</u> | | 10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>HUNGARY</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>FRED KOLLAK</u> | | 14. MOTHER'S MAIDEN NAME <u>BARBARA</u> ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address <u>SEA FORD</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>10 Yrs</u> <u>5 Yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from <u>4-15</u> , 1967, to <u>7-11</u> , 1967, that (X) (we) last saw the deceased alive on <u>7-11</u> , 1967, and that death occurred at <u>7:30</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>W B Sheer</u> | | 22b. DATE SIGNED <u>7-11-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER</u> | | 22d. ADDRESS <u>6400 MARLBORO PIKE SE. WASH. D.C. 20028</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>7/14/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State) <u>BROOKLYN, NEW YORK</u> | |
| 24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u> <u>4308 Suitland Road, Suitland, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>JUL 13 1967</u> DATE | |
| 25b. REGISTRAR'S SIGNATURE <u>J Charles Jones</u> | | | |

OFFICE OF THE SECRETARY OF THE ARMY

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TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY

RE: [illegible]

DATE: 11 July 1952

RE: [illegible]

RE: [illegible]

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RE: [illegible]

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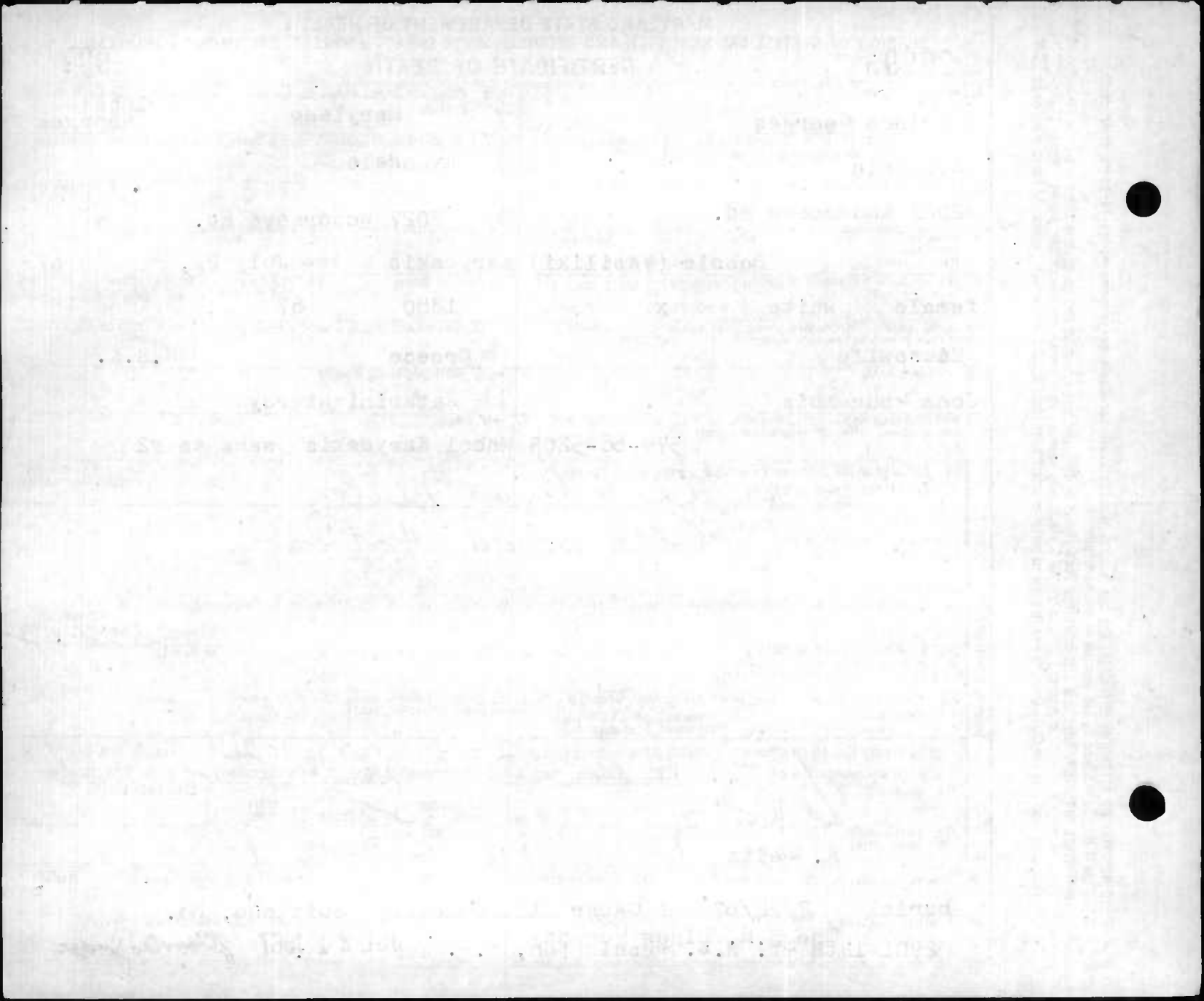
RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY, WASHINGTON, D.C. 20315

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09995 CERTIFICATE OF DEATH 09997

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale | | c. LENGTH OF STAY IN Ib | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2027 Woodreeve Rd. | | | | d. STREET ADDRESS 2027 Woodreeve Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Bessie (Vasiliki) Karydakis | | | | 4. DATE OF DEATH July 21, 1967 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1880 | |
| 9. AGE (in years last birthday) 87 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Greece | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Courembis | | | | 14. MOTHER'S MAIDEN NAME Katarini Nteroy | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 579-68-5203 | | 17. INFORMANT Mabel Karydakis | | Address same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Heart Disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (i) (this hospital) attended the deceased from 2-4 , 19 60 , to 7-21 , 19 67 , that (i) (we) last saw the deceased alive on 7-19 , 19 67 , and that death occurred at 10:44 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE A. Deitz | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) A. Deitz | | | | 22d. ADDRESS H. H. Hall & Co. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE THEREOF 7/24/67 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City, town or county) (State) Suitland, Md. | |
| 24. FUNERAL DIRECTOR The S. H. Hines Company 2901 14th St. N.W. Washington, D.C. | | | | 25a. REC'D BY REGISTRAR JUL 24 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|-----------------------------------|---|--|---|---|--|
| Item 2 Film 391 8-11-67 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 09996 | CERTIFICATE OF DEATH | 09998 |
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> | | c. LENGTH OF STAY IN 1b <u>10 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> Washington <u>473</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR NUR. HOMES</u> | | d. STREET ADDRESS <u>3244 38th Street, NW</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>VERA</u> Middle <u>M.</u> Last <u>Kelley</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1967</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1888</u> | 9. AGE (In years last birthday) <u>79</u> yrs. | 10. UNDER 24 HRS Months <u>7</u> Days <u>29</u> Hours <u>19</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY - RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>JUSTICE DEPT</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>NEBRASKA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>EDWARD KELLEY</u> | | 14. MOTHER'S MAIDEN NAME <u>ROSE WARD</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>- - -</u> | | 16. SOCIAL SECURITY NO. <u>- - -</u> | | 17. INFORMANT <u>HENRY FITZGERALD</u> Address <u>2226 N. TRENTON ST. ARLINGTON, VA.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chron. hypertensive coronary heart dis. = senility</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>67</u> to <u>7-29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-29</u> , 19 <u>67</u> , and that death occurred at <u>4: P.M.</u> , from causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE <u>Wm. M. Ballinger</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>7-29-67</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Wm. M. Ballinger M.D.</u> | | 22d. ADDRESS <u>5025 OVERLOOK DR. WASH. D.C.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8-1-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u> | | |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> | | ADDRESS <u>5130 Wisc. Ave. N.W. Wash. D.C.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 2 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D. C.

1. Name of Animal: _____
2. Sex: _____
3. Age: _____
4. Breed: _____
5. Color: _____
6. Markings: _____
7. Date of Birth: _____
8. Date of Examination: _____
9. Name of Owner: _____
10. Address: _____
11. City: _____
12. State: _____
13. Zip: _____

14. Name of Veterinarian: _____
15. Address: _____
16. City: _____
17. State: _____
18. Zip: _____
19. Date of Examination: _____
20. Name of Owner: _____
21. Address: _____
22. City: _____
23. State: _____
24. Zip: _____

25. Name of Veterinarian: _____
26. Address: _____
27. City: _____
28. State: _____
29. Zip: _____
30. Date of Examination: _____
31. Name of Owner: _____
32. Address: _____
33. City: _____
34. State: _____
35. Zip: _____

36. Name of Veterinarian: _____
37. Address: _____
38. City: _____
39. State: _____
40. Zip: _____
41. Date of Examination: _____
42. Name of Owner: _____
43. Address: _____
44. City: _____
45. State: _____
46. Zip: _____

47. Name of Veterinarian: _____
48. Address: _____
49. City: _____
50. State: _____
51. Zip: _____
52. Date of Examination: _____
53. Name of Owner: _____
54. Address: _____
55. City: _____
56. State: _____
57. Zip: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09997

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|--|---------------------------|---|---------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY in 1b 1 day | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George Hospital | | | | d. STREET ADDRESS 4100 Crittendon St., | | | |
| 3. NAME OF DECEASED (Type or print) First Charlotte Middle M Last Ketcham | | | | 4. DATE OF DEATH Month 7 Day 22 Year 19 67 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 24 Nov., 1876 | | 9. AGE (In years lost birthday) yrs. 90 | 10. IF UNDER 1 YEAR Months 7 Days 22 Hours 19 Min. 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME W. W. Moore | | | | 14. MOTHER'S MAIDEN NAME Emma Jobberns | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220 44 1542 | | 17. INFORMANT Paul Heyn Address 4728 Banner Street Hyatts., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) humerus Fell at home and sustained fractures of rt wrist and | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 7 p.m. 21 19 67 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) Same as #2 (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 7-22-67 | | 22. DATE SIGNED 7-22-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/25/67 | | 23c. NAME OF CEMETERY OR CREMATORY Arl. Natl. Ceme. | | 23d. LOCATION (City or Town) (County) (State) Arlington Va. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR JUL 27 1967 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | |

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(Signature)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10000

09998

CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b 8 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 1101 Oakdale Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Guss Middle S. Last Kidwell | | | | 4. DATE OF DEATH Month July Day 7 Year 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/3/1891 | | 9. AGE (In years lost birthday) yrs. 76 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soil Scientist | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | | 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George W. Kidwell | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-34-5980 | | 17. INFORMANT 2400 Queens Chapel Rd. Harry L. Kidwell, Hyattsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure DUE TO (c) Coronary arteriosclerotic heart disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 8 days months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis of superior mesenteric artery. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) this hospital attended the deceased from 1960 , 19 July 7 , 19 67 , that (1) we last saw the deceased alive on July 7 , 19 67 , and that death occurred at 12:30 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Leon R. Levitsky, M. D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. AM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M. D. | | | | 22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7-10-67 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincon Cemetery | | 23d. LOCATION (City or Town) (County) (State) Calmor Manor, Pr. Geo., Md. | |
| 24. FUNERAL DIRECTOR F. Gasch & Sons, Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DATE JUL 12 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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W. H. L.

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• *Journal of Management Education* 25(10):1133-1144

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

10001

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b 3 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital | | d. STREET ADDRESS 5017 Mineola Road | |
| 3. NAME OF DECEASED (Type or print) Warren Atherton King | | 4. DATE OF DEATH July 1 19 67 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 03/03/82 |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 11. BIRTHPLACE (County & State, or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? America | |
| 13. FATHER'S NAME King, Job | | 14. MOTHER'S MAIDEN NAME Philpot, Alice | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Same as #2 Miss Lillian Skidmore, Daughter | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X BRONCHOPNEUMONIA DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH ONE WEEK | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) CVA + RT. HEMIPLEGIA | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, public bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 11-23 , 19 66 , to 1 JULY , 19 67 , that (I) (we) last saw the deceased alive on 1 JULY 19 67 , and that death occurred at 3:38 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE C. J. Houmann | | 22b. DATE SIGNED 1 JULY '67 | |
| 22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN | | 22d. ADDRESS RIVERDALE MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF July 3, 1967 | 23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY | 23d. LOCATION (City or Town) (County) (State) K Steubenville, OHIO |
| 24. FUNERAL DIRECTOR Harold Swady, Samuel, Inc. | | 25a. REC'D BY REGISTRAR DATE JUL 3 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION

SECRET
U.S. GOVERNMENT PRINTING OFFICE: 1964

SECRET
U.S. GOVERNMENT PRINTING OFFICE: 1964

SECRET
U.S. GOVERNMENT PRINTING OFFICE: 1964

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i> c. LENGTH OF STAY IN 1b <i>16-1</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Geo</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i> | |
| 3. NAME OF DECEASED (Type or print) <i>JAMES LEE KIRBY</i> First Middle Last 4. DATE OF DEATH <i>July 7 1967</i> Month Day Year | | 5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Dec 24 1944</i> 22 yrs. 9. AGE (In years last birthday) 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Snack Dancer</i> 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Farmington West VA</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>John Paul Kirby Jr</i> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> 1962 16. SOCIAL SECURITY NO. <i>1962</i> | | 14. MOTHER'S MAIDEN NAME <i>Bertrice Kulber</i> 17. INFORMATIONAL Address <i>Records - Church</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple (3) gunshot wounds</i> 984X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>Shot by Peace Officers while resisting arrest</i> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <i>July 5 1967</i> 1:30 a.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Dwelling house Woodlawn P. Geo Md</i> 20f. (City or town) (County) (State) <i>Woodlawn Prince Georges Md</i> | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE <i>Dayton O Watkins</i> EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>July 7 1967</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <i>3318 Annapolis Rd</i> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Bladensburg Md</i> 22. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>7-11-1967</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i> 23d. LOCATION (City, town or county) (State) <i>Southland Prince Georges Md</i> | | 24. FUNERAL DIRECTOR <i>Robert H Mattingly</i> ADDRESS <i>131-11288 Washington</i> 25a. REC'D BY REGISTRAR <i>JUL 11 1967</i> 25b. REGISTRAR'S SIGNATURE <i>John H. Jones</i> | |

000011

Prime Property

Change

James Joseph

James E. Kirby

W M

24 1949

820 AVIS TOWN

James M. Smith

1525

10000

Dr. J. O. Watson

DATA ON WATER

July 7 1967

318

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
|--|--|------------------|-------------------|--|---|---|--|---|---------|--|------------------|-------|------|
| 10001 | | | | | 10003 | | | | | | | | |
| 1. PLACE OF DEATH 7500 HARWOOD RD. DISTRICT HEIGHTS | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | | | | | | |
| a. COUNTY | | PRINCE GEORGES | | | a. STATE | | Maryland | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | DISTRICT HEIGHTS | | | b. COUNTY | | Pr. Geo's | | | | | | |
| c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | District Heights, Md. | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 7500 - Harwood Road | | | | | 7500 - Harwood Road., SE | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | Last | 4. DATE OF DEATH | | Month | Day | Year | | | |
| | | RUTH | | E. | KLEIN | 7-28- | | 7 | 28 | 1967 | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | | |
| Female | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | March 3rd, 1920 | | 47 yrs. | | Months | Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Housewife | | | | Domestic | | | | Pittsburgh, Pa. | | USA | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | |
| Edward H. Klinzing | | | | | Anna Long | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | |
| no | | | | | | | Frank O. Klein - Same as # 2. | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA LUNGS- | | | | | | | | | | MAY 66 | | | |
| 170X DUE TO (b) ADENOCARCINOMA RT. BREAST | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) | | |
| Hour a.m. p.m. 19 | | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 9-2-66, 19 to 7-28, 1967, that (I) (we) last saw the deceased alive on 7-28-1967, and that death occurred at 1:15 P.M. from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | | | |
| LAWRENCE D. SUMMERFIELD, M.D. | | | | | | | | 7-28-67 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | | | | | |
| LAWRENCE D. SUMMERFIELD | | | | | | 3230 PA. AVE., S.E. WASH. D.C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town or county) (State) | | | | | |
| Burial | | | July 31, 67 | | Jefferson Memorial Cemetery, Pittsburgh | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Simmons Brothers | | | | | | DC | | AUG 1 1967 | | Charles J. [Signature] | | | |
| 1661-Gd. Hope Rd. SE. Wash. | | | | | | | | | | | | | |

10801

Female White X Ruth E. Klein J-28-N

AND FURTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10002

CERTIFICATE OF DEATH

10004

| | | | | | | | |
|--|-------------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b 2 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 8100 Marlboro Pike | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Laura Middle B. Last Koehler | | | | 4. DATE OF DEATH Month July Day 26 Year 19 67 | | | |
| 5. SEX Female | 6. COLOR OR RACE Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-6-87 | 9. AGE (In years last birthday) 80 yrs. | 10. IF UNDER 1 YEAR Months 6 Days 00 | 11. IF UNDER 24 HRS. Hours 00 Min. 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES BURLEY | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 579-12-7087 | | 17. INFORMANT LAURA B. WELCH | | Address 3400 LORRING DR FORESTVILLE MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Protein Septicemia 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic pyelonephritis DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (x) (this hospital) attended the deceased from July 24, 19 67 , to 7-26 , 19 67 , that (x) (we) last saw the deceased alive on 7-26 19 67 , and that death occurred at 7:45P M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Reginald C. Lee | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 7-28-67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. R. Lee | | | | 22d. ADDRESS Prince Georges General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 7-31-67 | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM | | 23d. LOCATION (City or Town) (County) (State) FT. MYER VA | | | |
| 24. FUNERAL DIRECTOR W.C. Chambers | | | | ADDRESS Riverdale Md. | | 25a. REC'D BY REGISTRAR JUL 31 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE James Judge | | | |

10003

RECEIVED OF DEPT.

RECEIVED OF DEPT. OF HEALTH

Office of General Hospital

July 1947

Female 1947

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

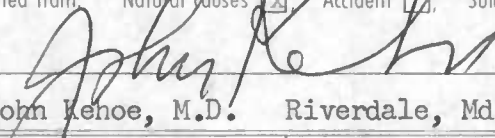
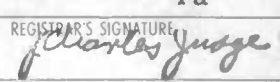
FOR STATE
HEALTH DEPT.

Items 18 & 21. Film #392 MARYLAND STATE DEPARTMENT OF HEALTH
9-13-67 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10003

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10005

| | | | | | | | |
|---|----------------------------------|---|---|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheltenham | | | | c. LENGTH OF STAY IN 1b 4 hours | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Station | | | | d. STREET ADDRESS 3416 Dangerfield Road | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle Joseph Last Kozak | | | | 4. DATE OF DEATH Month 7 Day 25 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 18 Aug. 1925 | | 9. AGE (In years lost birthday) yrs. 41 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security guard | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Ashley, Pa | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME John C Kozak | | | | 14. MOTHER'S MAIDEN NAME Joan Brown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT John C Kozak Address Allentown Pa | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intoxication-ethyl alcohol 3222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE  | | EXAMINER'S NAME (Type) John Kenoe, M.D. | | M.D. Riverdale, Md. | | 22. DATE SIGNED 7-26-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF July 26, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Weber Funeral Home | | 23d. LOCATION (City or Town) (County) (State) Allentown Pa | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR JUL 28 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE  | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11417

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|-------------------------------|---|--|---|--|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | | c. LENGTH OF STAY IN 1b <u>35 hrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Genral Hospital</u> | | | | d. STREET ADDRESS <u>4854 Eastern Lane</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Kruse</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1967</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>24 July 1967</u> | | 9. AGE (In years last birthday) yrs. <u>35</u> | 10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Candace Kruse</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Candace Kruse (mother)</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurity</u> 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atelectasis, bilateral</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that he (this hospital) attended the deceased from <u>July 24, 1967</u> , to <u>July 26, 1967</u> , that he (we) last saw the deceased alive on <u>July 26, 1967</u> , and that death occurred at <u>12:15 AM</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Patrick A. Reardon M.D.</u> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>7/27/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Patrick A. Reardon, M. D.</u> | | | | 22d. ADDRESS <u>Prince Georges General Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE THEREOF <u>8/5/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Prince George's Gen. Hosp.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Cheverly PG Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr., Admin.</u> | | | | 25a. REC'D BY REGISTRAR <u>AUG 9 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10004

CERTIFICATE OF DEATH

10006

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 21 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 5626 Whitfield Chapel Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Jessie Middle LANSFORD Last 4. DATE OF DEATH Month July Day 10 Year 1967 | | 5. SEX Female | |
| 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/22/90 | 9. AGE (In years last birthday) yrs. 76 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (County & State, or foreign country) North Carolina |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME Everitt Harrell | |
| 14. MOTHER'S MAIDEN NAME Martha Matthews | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | |
| 16. SOCIAL SECURITY NO. 577 20 7378 | | 17. INFORMANT Roger L. Herring Address Lanham, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arteriosclerosis, Generalized DUE TO (c) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus, Pneumonia | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) Dr. Rosson attended the deceased from 6/19/67 to 7/10/67 that (1) Dr. Rosson last saw the deceased alive on 7/10/67 and that death occurred at 7P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE William D. Rosson | | 22b. DATE SIGNED July 10, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) William D. Rosson, M. D. | | 22d. ADDRESS 5701 - 85th Ave. Hyattsville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF July 13, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. |
| 24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DATE JUL 13 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10006

CERTIFICATE OF DEATH

10007

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | | c. LENGTH OF STAY IN 1b 2 years & 53 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | | | d. STREET ADDRESS 3145 Mt. Pleasant St. N.W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) John Everett Ledbetter | | | | 4. DATE OF DEATH Month July Day 20 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-12-1908 | | 9. AGE (In years lost birthday) 59 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement worker | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (County & State, or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Horace Ledbetter | | | | 14. MOTHER'S MAIDEN NAME Kate Peland | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 1920-24 Army 245-01-2782 | | 17. INFORMANT (Decedent) Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized arteriosclerosis with arteriosclerotic heart disease (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Paralysis agitans. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/28 , 19 65 , to 7/20 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/20 , 19 67 , and that death occurred at 4:35 P.M. , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Moe Weiss</i> | | | | ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 7/20/67 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7-26-67 | | 23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery | | 23d. LOCATION (City or Town) (County) (State) Canton N.C. | |
| 24. FUNERAL DIRECTOR F. B. Archib | | | | 25a. REC'D BY REGISTRAR DATE JUL 27 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

10000

D.C.

Glenn Dale Hospital

Glenn Dale Hospital

John

Everett

Male

White

General worker

Marine Hospital

Yes

1917-18 Army

305-01-1782

(Resident)

Bronchopneumonia

3 days

Generalized arteriosclerosis with atherosclerosis of the heart

Paralytic agnosia.

Dr. Walter, M.D.

Glenn Dale Hospital
Glenn Dale, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10008

10006

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> | | | | c. LENGTH OF STAY IN 1b <u>DoA</u> | | | |
| d. STREET ADDRESS <u>Capital Heights</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u> | | | | d. STREET ADDRESS <u>205-61 ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Fred Washington Leonard</u> | | | | 4. DATE OF DEATH <u>July 6 1967</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug 7 1914</u> | |
| 9. AGE (In years, months, days, hours, minutes) <u>52 yrs.</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 MRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Restaurant</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>William Leonard</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lulu Mae Davenport</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW 2</u> | | | | 16. SOCIAL SECURITY NO. <u>225-03-3859</u> | | 17. INFORMANT <u>Mrs. Gladys McHarn</u> Address <u>205-61 ave Capital HTS MD</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>few minutes</u> DUE TO (b) <u>Congestive Heart failure</u> <u>years</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <u>7-6-67</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5318 Annapolis Rd</u> | | | |
| | | | | Address (Street, city, town, or county) <u>Beadensburg Md</u> | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>7/10/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>WALL NEW PARK</u> | | 23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH VA</u> | |
| 24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co. WASH DC</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 11 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10007

CERTIFICATE OF DEATH

10009

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY P.G. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b 12 hours | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville | | d. STREET ADDRESS 6319 23rd Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Furman J. Lindsay | | 4. DATE OF DEATH Month 7 Day 22 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-8-98 |
| 9. AGE (In years lost birthday) yrs. 68 | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Starch Co. | |
| 11. BIRTHPLACE (County & State, or foreign country) N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Zeb Lindsay | | 14. MOTHER'S MAIDEN NAME Minnie Howell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. 300-03-4364 | |
| 17. INFORMANT Hospital records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac Gastro-Enteritis, non specific 5711 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration, myocardial failure - DUE TO (c) & pericardial circulation collapse 3 days | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic/Hypertensive Cardio-vascular disease | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 20, 1967 , to July 22, 1967 that (I) (we) last saw the deceased alive on July 21, 1967 , and that death occurred at 2:30 P.M. from cause and on the date stated above. | | 22a. SIGNATURE W.L. Etienne | |
| 22b. PHYSICIAN'S NAME (Type) W.L. ETIENNE | | 22c. ADDRESS College Park, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/24/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Evergreen Cem. | | 23d. LOCATION (City or Town) (County) (State) Charlotte, N. Car. | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | 25a. REC'D BY REGISTRAR JUL 24 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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Arthur Robert Hughes
2000

2 18 July

W. L. Etienne

James
C. Smith

Deep Port, N.Y. 7-22-07

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

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| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USAF Hospital Andrews | | | | c. LENGTH OF STAY IN 1b 5 Days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First GERTRUDE Middle ARLENE Last LYDICK | | | | 4. DATE OF DEATH Month JULY Day 5 Year 19 67 | | | |
| 5. SEX Female | 6. COLOR OR RACE Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 28 Aug 1928 | 9. AGE (In years lost birthday) 38 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY NA | | 11. BIRTHPLACE (County & State, or foreign country) Assumption, Illinois | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JAMES CARSON | | | | 14. MOTHER'S MAIDEN NAME AILCIE SCOLES | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No NA | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Husband-same as item #2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hodgkins Disease DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of left breast | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that XX (this hospital) attended the deceased from 19 60 , to 5 July , 19 67 that X (we) lost the deceased alive on 5 July , 19 67 and that death occurred at 935a a.m., from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Charles D. Phelps</i> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 5 July 1967 | |
| 22c. PHYSICIAN'S NAME (Type) CHARLES D. PHELPS, CAPT, USAF, MC | | | | 22d. ADDRESS USAFH Andrews AFB, Wash DC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 7, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Va. | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR Simmons Bros. | | | | 25a. REC'D BY REGISTRAR JUL 7 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |
| 26. ADDRESS Simmons Bros. 1661- Gd. Hope Rd. SE. Wash., DC | | | | | | | |

10000

CERTIFICATE OF DEATH

Prince George

Karlens

Prince George

USAF Hospital Andrews

5 Days

Oxon Hill

USAF Hospital Andrews

5105 Wilmette Drive

SHUTRUD

AKLANT

LYDICK

JULY

18 Aug 1938

Female

Honolulu

HA

Assessment, Illinois

JAMES CANNON

ALLIE SCOTT

HA

Husband same as item 52

Respiratory Failure

Respiratory Failure

Capitulum of left breast

AK

5 July

67

0325

5 July

67 X

5 July 1967

CHARLES D. BUELL, CAPT, USAF, MC USAF, Andrews AFB, Wash DC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1000S

CERTIFICATE OF DEATH

10011

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>PR Geo</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4811 Fox ST.</u> | | c. LENGTH OF STAY IN 1b <u>8 mos</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>COLLEGE PARK</u> | | d. STREET ADDRESS <u>352 GILES ST.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Jennie Wilton Macklem</u> | | 4. DATE OF DEATH <u>July 18 1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 4, 1882</u> |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>Henry Wilkinson</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Lucinda Walker</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>218-54-5817</u> | |
| 17. INFORMANT <u>Mrs Mary Real</u> | | Address <u>see #1 above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Corrosive Heart Failure</u> DUE TO (b) <u>Chronic Ischemic Heart Disease</u> DUE TO (c) <u>Myocardial Failure</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>45</u> to <u>July 67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>July 18 1967</u> , and that death occurred at <u>10 P</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>W. L. Etienne</u> | | 22b. DATE SIGNED <u>7-18-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u> | | 22d. ADDRESS <u>College Park, Ind</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>JULY 21, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>ROCKY HILL CEM.</u> | 23d. LOCATION (City or Town) (County) (State) <u>HARFORD Co. MD.</u> |
| 24. FUNERAL DIRECTOR <u>R. Madison Mitchell, Harford, Md.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE | | DATE <u>JUL 24 1967</u> | |

20005

COLLEGE PARK

James Wilson

F W

Henry Williams

MAY 4 1950

JULY 18 50

215-2517th Hwy Rd
Route 20000 Hwy Rd
Carmichael Hwy Rd
5 Highway Rd

Henry Williams
MAY 4 1950

W. E. Evans
JULY 15 50

College Park, Md
JULY 15 50

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10010

CERTIFICATE OF DEATH

10012

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S COUNTY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DISTRICT of COLUMBIA</u> b. COUNTY <u>PRINCE GEORGE'S</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> | | c. LENGTH OF STAY IN 1b <u>9 YRS.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR</u> | | d. STREET ADDRESS <u>3850 TUNLAW ROAD NW</u> | |
| 3. NAME OF DECEASED (Type or print) <u>MRS GERTRUDE C. MAHER</u> | | 4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1967</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/4/1873</u> |
| 9. AGE (In years lost birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>PORTLAND, MAINE</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JAMES CUNNINGHAM</u> | | 14. MOTHER'S MAIDEN NAME <u>KATHERINE MULLEN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>006-07-6143</u> | |
| 17. INFORMANT <u>SR. IMMACULATA O. CARM</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis of the Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C Acute pulmonary edema</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH. <u>2 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> , 19 <u>66</u> , to <u>July 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 9</u> , 19 <u>67</u> , and that death occurred at <u>3 PM</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Thomas F. Collins</u> | | 22b. DATE SIGNED <u>July 10, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Thomas F. Collins, M.D.</u> | | 22d. ADDRESS <u>322 H Street, N.E., Washington, D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>July 13, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery,</u> | 23d. LOCATION (City or Town) (County) (State) <u>Portland, Maine.</u> |
| 24. FUNERAL DIRECTOR <u>A. Dow, DEVO</u> | | 25a. REC'D BY REGISTRAR <u>2222 W. Ave. N. W.</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>JUL 12 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

REPORT OF DISEASE

100000

100000

6

UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY MEDICAL DEPARTMENT, WASHINGTON, D. C. 20315

10011

CERTIFICATE OF DEATH

10013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>P.A. Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.B.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fr Geo Gen'l Hosp.</u> | | d. STREET ADDRESS <u>7900 West Park Drive</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Grant</u> Last <u>Marshall</u> | | 4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/31/1890</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Washington Post paper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>California</u> | | 12. CITIZEN OF WHAT COUNTRY? <u> </u> | |
| 13. FATHER'S NAME <u>unobtainable</u> | | 14. MOTHER'S MAIDEN NAME <u>unobtainable</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>578-38-5868</u> | |
| 17. INFORMANT <u>John W. Marshall</u> | | Address <u>(same as above)</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia (terminal)</u> 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>severe Multiple Cerebral vascular accidents</u> (c) <u>severe generalized arteriosclerosis & nephrosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 mo.</u> <u>3-5 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> |
| 21. I certify that <u>0</u> (this hospital) attended the deceased from <u>6-18</u> , 19 <u>67</u> , to <u>7-8</u> , 19 <u>67</u> , that <u>0</u> (we) last saw the deceased alive on <u>7-8</u> , 19 <u>67</u> , and that death occurred at <u>1:32 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>R.D. Baker M.D.</u> | | 22b. DATE SIGNED <u>7-8-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>R.D. Baker, M.D.</u> | | 22d. ADDRESS <u>2513 Buck Lodge Rd. Adelphi Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE THEREOF <u>7/11/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u> | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u> |
| 24. FUNERAL DIRECTOR <u>S.H. HINES Co.</u> | | ADDRESS <u>Washington</u> DC REC'D BY REGISTRAR <u>JUL 11 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

10011

DEPARTMENT OF STATE

Mexico

Haverrville

1900 West Park Drive

Marshall

Great

Eva

1931/2000

Received - Washington Post report - California

unobtainable

unobtainable

500-30-3000 (same as above)

Handwritten notes and signatures, including "Marshall" and "Eva".

Handwritten notes and signatures, including "Marshall" and "Eva".

Handwritten notes and signatures, including "Marshall" and "Eva".

Handwritten notes and signatures, including "Marshall" and "Eva".

Handwritten notes and signatures, including "Marshall" and "Eva".

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10012

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10014

| | | | | | | | |
|---|--|--------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo D.C.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Dc</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u> | | | | d. STREET ADDRESS <u>4523 Arkansas Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ANTHONY MASSEY</u> | | | | 4. DATE OF DEATH Month Day Year <u>July 11 1967</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>C</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| 9a. AGE (In years last birthday) <u>47-3</u> | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child Student</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Leonard McCoy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Bernice McCoy</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning -</u> <u>few minutes</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>abrasions on chest - Bruises on Rt Forehead</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Subject Drowned in a Sunny Pool</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | |
| 20f. (City or town) <u>Arlington</u> (County) <u>Pr Geo</u> (State) <u>MD</u> | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-12-67 | | | |
| EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 5318 <u>Ann</u> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bladenburg</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>7/17/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY</u> | |
| 23d. LOCATION (City or Town) <u>Prince Geos. Co. MD</u> (County) <u>Pr Geo</u> (State) <u>MD</u> | | | | 23e. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |
| 24. FUNERAL DIRECTOR <u>3900 GEORGIA AVENUE, N. W.</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 17 1967</u> DATE | | | |

10001

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10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10013

CERTIFICATE OF DEATH

10015

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b 12 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital | | d. STREET ADDRESS College Park | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Margaret H. Mathews | | 4. DATE OF DEATH Month Day Year July 26 19 67 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/20/95 |
| 9. AGE (In years last birthday) 72 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles S. Higgs | | 14. MOTHER'S MAIDEN NAME Ella Ward | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 212-54-7941 | |
| 17. INFORMANT hospital records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Cholemia, secondary to Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Glomerulo-nephritis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/6/67 , 19 67 to 7/26 , 19 67 , that (I) (we) last saw the deceased alive on 7/26 , 19 67 , and that death occurred at 10:15 M, from causes on and on the date stated above. | | 22a. SIGNATURE W. L. Etienne M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) W. L. Etienne | | 22d. ADDRESS College Park Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE THEREOF 7/27/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) Cumberland, Md. | |
| 24. FUNERAL DIRECTOR J. H. HINES Co. | | 25a. REC'D BY REGISTRAR JUL 28 1967 | |
| ADDRESS 2901 14th NW D.C. | | 25b. REGISTRAR'S SIGNATURE James J. Jones | |

1901

James, Secretary to U.S. 301
James, Secretary to U.S. 301

W. L. Etienne
4/10/07

4/10/07
4/10/07
4/10/07

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10014

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10016

| | | | | | |
|--|----------------------------------|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS Rural | |
| 3. NAME OF DECEASED (Type or print) John Harding Mattera | | | 4. DATE OF DEATH Month 7 Day 23 Year 1967 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 17 Nov. 1945 | 9. AGE (In years lost birthday) 21 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linesman (Empl'd) | | 10b. KIND OF BUSINESS OR INDUSTRY Public Electric Utility | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. U. S. A. | |
| 13. FATHER'S NAME Harding Mattera | | | 14. MOTHER'S MAIDEN NAME Mary E. Pell | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. -- | | 17. INFORMANT Mr. Harding Mattera-Huntingtown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution 9143 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Electrocuted while working on high tension wires. | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3:15am 7-23- 1967 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7900 Annapolis Road, Prince George Co., Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 7-24-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | RIVERDALE, MD. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/26/67 | | 23c. NAME OF CEMETERY OR CREMATORY Christ Church Com. | |
| | | | | 23d. LOCATION (City or Town) (County) (State) Port Republic, Md. | |
| 24. FUNERAL DIRECTOR A.A. Harkness & Son | | ADDRESS Mutual, Md. | | 25a. REC'D BY REGISTRAR JUL 28 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

10016

Harding Matters

Jameson (Baptist)

Public Health

Washington, D. C. U. S. A.

Mary E. Hall

Mr. Harding Matters-Harding Matters

No

Serial 7/26/07

Christ Church Gen.

Port Republic, Md.

Mutual, Md.

A. A. Harkness & Son

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10015

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10017

| | | | |
|--|--|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u> | | d. STREET ADDRESS <u>5712 Camp Springs ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Mazzucco</u> Last <u></u> | | 4. DATE OF DEATH <u>July 4 1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 8 1916</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>produce mgr</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>grand union</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington DC</u> | | 12. COUNTRY OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James Mazzucco</u> | | 14. MOTHER'S MAIDEN NAME <u>Maria Valerio</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW 2</u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Anthony Mazzucco - n</u> Address <u>Camp Springs</u> | | 17. INFORMANT <u>5712 Camp Springs ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>Year</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Dayton O Watten</u> | | 22. DATE SIGNED <u>July 5 1967</u> | |
| EXAMINER'S NAME (Type) <u>DAYTON O WATTEN</u> | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July, 7-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Washington, DC.</u> | |
| 24. FUNERAL DIRECTOR <u>Simmons Bros.</u> ADDRESS <u>1661-Gd. Hope Road SE. Wash., DC</u> | | 25a. REC'D BY REGISTRAR <u>JUL 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10016

CERTIFICATE OF DEATH

10018

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> | | c. LENGTH OF STAY in 1b <u>20 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> <u>16-1</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9 Forestway</u> | | | | d. STREET ADDRESS <u>9 Forestway</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>James W. McCarl</u> First Middle Last | | | | 4. DATE OF DEATH <u>July 14</u> 19 <u>67</u> Month Day Year | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 13, 1895</u> | |
| 9. AGE (In years lost birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Newton Mc Carl</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Alice Henderson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>213-38-2675</u> | | 17. INFORMANT <u>Delpha Mc Carl</u> Address <u>9 Forestway Greenbelt, Maryland</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASHD</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-5-65</u> , 19____, to <u>7-14-67</u> 19____, that (I) (we) last saw the deceased alive on <u>7-12-67</u> 19____, and that death occurred at <u>9:45 AM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>James J. Feffen</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>7-14-67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>James J. Feffen</u> | | | | 22d. ADDRESS <u>1711 R. L. Ave. N.H.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 17, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Glenn Carter</u> <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>JUL 19 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

10018

RECORD OF DEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME 57
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10017

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10019

| | | | | | | | |
|--|------------------------------|--|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>PV Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>PV Geo</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overdale</u> | | c. LENGTH OF STAY IN 1b- <u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belleville</u> <u>Calverton</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Leeland Memorial Hosp</u> | | | | d. STREET ADDRESS <u>3411 Fullerton St</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>MATTHEW</u> Middle <u>SCOTT</u> Last <u>McDONALD</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1967</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 25 1942</u> | 9. AGE (In years last birthday) <u>25</u> | IF UNDER 1 YEAR Months <u>3</u> Days <u>18</u> | | IF UNDER 24 HRS. Hours <u>18</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>George H McDonald</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Constance Swift</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT <u>George McDonald</u> Address <u>Fullerton St Belleville Md</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>522X</u> IMMEDIATE CAUSE (a) <u>Pulmonary Edema (SDII)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Dayton O. Watkins</u> EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>July 11 1967</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>3318 Ramapark Rd</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bladensburg Md</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 13, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Adelphi, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>8434 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Md.</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>JUL 14 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

7100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10018

10020

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Pro George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Lillian Middle G. Last Molitor | | 4. DATE OF DEATH Month July Day 4 Year 1967 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 18, 1923 |
| 9. AGE (in years last birthday) 44 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY Food Company | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A. | |
| 13. FATHER'S NAME Carlos D Gibbs | | 14. MOTHER'S MAIDEN NAME Ethel E Steele | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 577 24 6575 | |
| 17. INFORMANT Carl W Molitor | | Address Hyattsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 330X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebellar Infarction right (c) Central arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 8 days 1 1/2 yrs. 2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7/4 , 19 67 , to 7/4 , 19 67 , that (I) (we) last saw the deceased alive on 7/4 , 19 67 , and that death occurred at 3:07 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Norman J. Bineau | | 22b. DATE SIGNED 7/4/67 | |
| 22c. PHYSICIAN'S NAME (Type) NORMAN J. BINEAU | | 22d. ADDRESS 3503 Pennysil APT Raisen md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF July 7, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | 23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md. |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Maryland. | |
| 25a. REC'D BY REGISTRAR JUL 7 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

10018

THOMAS C. O'NEIL

1907

THOMAS C. O'NEIL

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THOMAS C. O'NEIL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

10019

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10021

| | | | | | | | |
|---|---------------------------|--|---------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Pr Geo</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>DEBBIE KAY MOOMAW</u> | | | | 4. DATE OF DEATH <u>July 1</u> 19 <u>67</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-24-67</u> | 9. AGE (In years last birthday) <u>2</u> yrs. | IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u> | | IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Jerry Moomaw</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Josephine Myers</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT <u>Mrs Josephine Moomaw</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SPIT</u> 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>interstitial</u> DUE TO <u>pneumonitis, bilaterally</u> (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Dayton O Watkins</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>5318 Anna Kelsch</u> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bladensburg Rd</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | | 23b. DATE THEREOF <u>7/3/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Weyers Methodist Ch.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Weyers Cave, Virginia</u> | |
| 24. FUNERAL DIRECTOR <u>The S.H. Hines Compan</u> ADDRESS <u>Washington, D.C.</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 5 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u> | |

MEDICAL CERTIFICATION

2100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10020

CERTIFICATE OF DEATH

10022

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | | | c. LENGTH OF STAY IN TB 10 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. | | | |
| f. STREET ADDRESS 1620 A St., S.E. | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First James Middle Moore Last Moore | | | | 4. DATE OF DEATH Month July Day 13 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/23/14 | 9. AGE (In years last birthday) 53 yrs. | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | IF UNDER 24 HRS. Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY unknown | | 11. BIRTHPLACE (County & State, or foreign country) N.C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Samuel Moore | | | | 14. MOTHER'S MAIDEN NAME Martha Stone | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT decendent Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease (c) Coronary artery disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Essential hypertension, left cerebrovascular accident | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/3/ , 19 67 , to 7/13/67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/13/ 19 67 , and that death occurred at 7:25PM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Moe Weiss | | | | 22b. DATE SIGNED 7/13/67 | | 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | |
| 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md. | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) Buried | | 23b. DATE THEREOF 7-18-1967 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony MEM CEMETERY | | 23d. LOCATION (City or Town) (County) (State) Landover Md | |
| 24. FUNERAL DIRECTOR William Spangler | | | | 25a. REC'D BY REGISTRAR JUL 17 1967 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

10000

Prince Georges

Glenn Dale (rural) 10 days Washington, D. C.

Glenn Dale Hospital 1020 A St., S.E.

| Male | Female | Age | Notes | Date |
|--------------|--------|-----|-------|---------|
| Robert | James | 23 | known | July 25 |
| Samuel Moore | Robert | 23 | known | July 25 |

| Male | Female | Age | Notes | Date |
|--------------|--------|-----|-------|---------|
| Robert | James | 23 | known | July 25 |
| Samuel Moore | Robert | 23 | known | July 25 |

| Male | Female | Age | Notes | Date |
|--------------|--------|-----|-------|---------|
| Robert | James | 23 | known | July 25 |
| Samuel Moore | Robert | 23 | known | July 25 |

| Male | Female | Age | Notes | Date |
|--------------|--------|-----|-------|---------|
| Robert | James | 23 | known | July 25 |
| Samuel Moore | Robert | 23 | known | July 25 |

| Male | Female | Age | Notes | Date |
|--------------|--------|-----|-------|---------|
| Robert | James | 23 | known | July 25 |
| Samuel Moore | Robert | 23 | known | July 25 |

| Male | Female | Age | Notes | Date |
|--------------|--------|-----|-------|---------|
| Robert | James | 23 | known | July 25 |
| Samuel Moore | Robert | 23 | known | July 25 |

| Male | Female | Age | Notes | Date |
|--------------|--------|-----|-------|---------|
| Robert | James | 23 | known | July 25 |
| Samuel Moore | Robert | 23 | known | July 25 |

| Male | Female | Age | Notes | Date |
|--------------|--------|-----|-------|---------|
| Robert | James | 23 | known | July 25 |
| Samuel Moore | Robert | 23 | known | July 25 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10021

CERTIFICATE OF DEATH

10023

| | | | |
|---|----------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY in 1b 20 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | 16.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | d. STREET ADDRESS 5354 Quincy Place | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Albert Middle G. Last Morrow | | 4. DATE OF DEATH Month July Day 31 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 1919 |
| 9. AGE (In years lost birthday) yrs. 48 | | IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Min. 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repairman | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Georgia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Albert Morrow | | 14. MOTHER'S MAIDEN NAME Ethel Turner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 240-16-9028 | |
| 17. INFORMANT (Son-in-law) Address Robert Benson Falls Church, Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 5410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PNEUMONIA DUE TO (c) MASSIVE G.I. BLEEDING DUE TO ADRENAL ULCER | | INTERVAL BETWEEN ONSET AND DEATH 18 days 21 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC EMPHYSEMA | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from July 11, 1967 , to July 31, 1967 that (I) (we) last saw the deceased alive on July 31, 1967 , and that death occurred at 7:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Felix Flores MD | | 22b. DATE SIGNED 8/1/67 | |
| 22c. PHYSICIAN'S NAME (Type) FELIX FLORES MD | | 22d. ADDRESS Prince Georges General Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE OF INTERMENT 8-2-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fairfax Mem. Gardens | | 23d. LOCATION (City or Town) (County) (State) Fairfax, Va. | |
| 24. FUNERAL DIRECTOR Falls Church F. H. | | 25a. REC'D BY REGISTRAR AUG 4 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

10021

CERTIFICATE OF MARRIAGE

State of New York

County of Albany

City of Albany

State of New York

County of Albany

City of Albany

County of Albany

City of Albany

State of New York

20-10-1900

CARDINAL ARREST

PNEUMONIA

WASTING & BEEFING DUE TO
DYSPEPSIA & ACID

CHRONIC EMPHYSEMA

July 31, 1901

Felix Flores MD.

FELIX FLORES MD.

8-1-1901

State of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10022

Item #9 Film #G391 8/17/67 ph

CERTIFICATE OF DEATH

10034

| | | | | | | | |
|---|--------------------------------------|---|--|---|---|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE | | c. LENGTH OF STAY in 1b 3 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RICHMOND | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL | | | | d. STREET ADDRESS 9308 OVERHILL ROAD | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM IGNATIUS MURRAY | | | | 4. DATE OF DEATH Month Day Year JULY 28 19 67 | | | |
| 5. SEX MALE | 6. COLOR OR RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 31 DEC 1917 | 9. AGE (In years last birthday) 48 49 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIEF WARREN OFFICER RET U.S. AIR FORCE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANNIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN IGNATIUS MURRAY | | | | 14. MOTHER'S MAIDEN NAME MARGARET CHAMBERS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1938-1959 | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address HELEN W MURRAY-WIFE-SAME AS #2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UPPER GASTROINTESTINAL HEMMORRHAGE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 26 JUL , 19 67 , to 28 JUL , 19 67 , that (I) (we) last saw the deceased alive on 28 JULY , 19 67 , and that death occurred at 10:51M , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>GAETANO F MOLINARE</i> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 29 JULY 67 | |
| 22c. PHYSICIAN'S NAME (Type) GAETANO F MOLINARE CAPT USAF MC | | | | 22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 8/1/67 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington Co. Va. | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR Heasley Funeral Home Alexandria, Va. | | | | 25a. REC'D BY REGISTRAR DATE AUG 2 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10028

Item 2 film G391 7/26/67

CERTIFICATE OF DEATH

10025

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Pr. Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PHILADELPHIA</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> | | c. LENGTH OF STAY IN 1b <u>1 month</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | 15. 2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Convalescent Home</u> | | d. STREET ADDRESS <u>6857 Battery Lane</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>John Edwin Nell</u> | | 4. DATE OF DEATH Month Day Year <u>July 13, 1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 20, 1883</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office mgr.</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Pattern Atty's.</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>Steelton, Penna.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Levi Henry Nell</u> | | 14. MOTHER'S MAIDEN NAME <u>Mabel Brown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>578-05-8615</u> | |
| 17. INFORMANT <u>Sister Kathryn Nell</u> | | Address <u>Box 107 Dauphin, Penna.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic</u> <u>1538</u> DUE TO <u>Colon CA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Colon CA</u> DUE TO (c) <u>Metastatic CA from liver to brain</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 to 8 mos.</u> <u>2 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 14, 1967</u> to <u>JULY 13, 1967</u> , that (I) (we) lost the deceased alive on <u>JULY 13, 1967</u> , and that death occurred at <u>6:24 M.</u> from causes on the date stated above. | | | |
| 22a. SIGNATURE <u>Hans Wodak</u> | | 22b. DATE SIGNED <u>7-13-1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HANS WODAK M.D.</u> | | 22d. ADDRESS <u>GREENBELT, PROF. BLDG., GREENBELT, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE THEREOF <u>7-15-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>JUL 19 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

10024

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10026

| | | | | | | | |
|---|---------------------------|---|--------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside Maryland</u> | | | | c. LENGTH OF STAY IN 1b - <u>DOA</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> | | | | 16.1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1116-56 ave</u> | | | | d. STREET ADDRESS <u>1116-56 ave</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>DOROTHY</u> First <u>O'NEIL</u> Middle <u>O'NEIL</u> Last | | | | 4. DATE OF DEATH <u>July 10</u> 19 <u>67</u> Month Day Year | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 24, 1916</u> | 9. AGE (In years last birthday) <u>50</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTH PLACE (State or foreign country) <u>Alexandria Va</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Elliatt</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Martha Jacobs</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs Joanne O'Neill, same as above</u> Address <u>daughter</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple stab wounds of chest and abdomen;</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with lacerations of the right lung, right kidney and liver.</u> DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>External violence</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>stabbing</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3:00</u> p.m. <u>7/10/67</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>Hillside PG Maryland</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Dayton O Watkins</u> | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>7-10-67</u> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>5318 annapolis rd</u> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bladensburg Md</u> | | | |
| | | | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/14/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Alexandria, Virginia</u> | |
| 24. FUNERAL DIRECTOR <u>Carroll Cadell</u> ADDRESS <u>DEMAINS FT. ALEXANDRIA VA</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 12 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10025

CERTIFICATE OF DEATH

10027

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|--|---------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN lb 28 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Madison Manor Nursing Home | | d. STREET ADDRESS 5700-39th Avenue | |
| 3. NAME OF DECEASED (Type or print) First BESSIE Middle R. Last OSGOOD | | 4. DATE OF DEATH Month July Day 9 Year 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE Cau. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/27/1882 |
| 9. AGE (In years last birthday) 85 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 12. KIND OF BUSINESS OR INDUSTRY Home | |
| 13. BIRTHPLACE (County & State, or foreign country) Canada | | 14. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. FATHER'S NAME William Ryder | | 16. MOTHER'S MAIDEN NAME Lottie Kent | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 18. SOCIAL SECURITY NO. XXXX | |
| 19. INFORMANT Henry R. Osgood | | Address Son Hyattsville, Md. | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Carcinoma of lung DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 months Months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerotic Heart Disease | | 21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 22. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 23. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 24. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 25. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 26. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 27. (City or town) (County) (State) | |
| 28. I certify that (I) (this hospital) attended the deceased from March , 19 67 , to 7-9 , 19 67 , that (I) (we) last saw the deceased alive on 7-8 , 19 67 , and that death occurred at 4:25 PM , from causes and on the date stated above. | | | |
| 29. SIGNATURE Donald C. Edgren | | 30. DATE SIGNED | |
| 31. PHYSICIAN'S NAME (Type) DONALD C. EDGREN | | 32. ADDRESS Hyattsville, Md. | |
| 33. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 34. DATE THEREOF 7/13/1967 | |
| 35. NAME OF CEMETERY OR CREMATORY Riverside | | 36. LOCATION (City or Town) (County) (State) Ft. Fairfield Maine | |
| 37. FUNERAL DIRECTOR GASCH'S | | 38. ADDRESS HYATTSVILLE, MARYLAND | |
| 39. REC'D BY REGISTRAR JUL 12 1967 | | 40. REGISTRAR'S SIGNATURE Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10026

CERTIFICATE OF DEATH

10026

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|-------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | | | c. LENGTH OF STAY IN 1b <u>6 days</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u> | | | | d. STREET ADDRESS <u>College Park</u> <u>5201 Kennisaw Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>M</u> Last <u>Owen</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>67</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC 13, 1891</u> | 9. AGE (In years lost birthday) <u>75 yrs.</u> | IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> Hours <u>67</u> | | IF UNDER 24 HRS. Mm. <u>67</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>JAMES OWEN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>HAMBLETON FREELAND</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>MRS ETHEL BREWER</u> Address <u>5806 DEWEY ST CHEVERLY, MD</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LACTIC ACIDOSIS</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARDIAC ARREST</u> DUE TO (c) <u>METASTATIC BREAST CANCER</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that <u>(*)</u> (in hospital) attended the deceased from <u>7/10/67</u> , 19 <u>67</u> to <u>7/16/67</u> , 19 <u>67</u> , that <u>(*)</u> (we) last saw the deceased alive on <u>July 16</u> , 19 <u>67</u> , and that death occurred <u>8:15 PM</u> M, from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Saul W. Rosen, M.D.</u> | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) <u>Dr. Saul W. Rosen, M.D.</u> | |
| 22d. ADDRESS <u>BN242 NIH Clinical Center, Bethesda, Md.</u> | | | | 22e. REC'D BY REGISTRAR | | | |
| 22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | 22g. DATE SIGNED <u>JUL 24 1967</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| <u>BURIAL</u> | | <u>JULY 22, 1967</u> | | <u>FT. LINCOLN CEM.</u> | | <u>BLADENSBURG MARYLAND</u> | |
| 24. FUNERAL DIRECTOR <u>W.W. CHAMBERS</u> ADDRESS <u>60 RIVERDALE, MD</u> | | | | 25. REGISTRAR'S SIGNATURE | | | |

Place of Birth _____
Date of Birth _____
Place of Death _____
Date of Death _____
Cause of Death _____
Signature of Physician _____
Signature of Registrar _____
Date _____

10000
CERTIFICATE OF DEATH
IN THE DISTRICT OF COLUMBIA
Date _____
Signature of Registrar _____
Signature of Physician _____
Date _____

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10027

10029

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--------------------------------------|---|---------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PG | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE | | c. LENGTH OF STAY IN TB 2 HOUR 17 MIN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS | | | | d. STREET ADDRESS 6915 NORTH GATE PARKWAY | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First GARY WAYNE OWENS Middle OWENS Last OWENS | | | | 4. DATE OF DEATH Month JULY Day 28 Year 19 67 | | | |
| 5. SEX MALE | 6. COLOR OR RACE CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 28 JULY 67 | | 9. AGE (In years lost birthday) yrs. 28 | IF UNDER 1 YEAR Months 2 Days 17 | IF UNDER 24 HRS. Hours 2 Min. 17 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME RUSSELL (NMI) OWENS | | | | 14. MOTHER'S MAIDEN NAME SHARON KAY WEIDLER | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address BILLIE J WEIDLER-GRANDMOTHER-SAME AS #2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY INADEQUACY 5604 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MASSIVE HIATUS HERNIA DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 HRS 17 MIN |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that XX (this hospital) attended the deceased from 28 JUL , 19 67 , to 28 JUL , 19 67 , that XX (we) lost the deceased alive on 28 JUL , 19 67 , and that death occurred at 11:51M , from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Roger E Spitzer, MD M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED 31 July 1967 | | | |
| 22c. PHYSICIAN'S NAME (Type) ROGER E SPITZER CAPT USAF MC | | | | 22d. ADDRESS USAF HOSPITAL CAMP SPRINGS, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 2nd-67 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City or Town) (County) (State) Arlington, Va | |
| 24. FUNERAL DIRECTOR Simmons Bros. ADDRESS Simmons Bros.-1661-Good Hope Rd SE Wash DC | | | | 25a. REC'D BY REGISTRAR AUG 1 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

10051

(M)

ADP 1 HBT

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

10028

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10030

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Prince George's b. COUNTY Maryland | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b D.O.A | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Hill, | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince GEorge's General Hospital | | | | d. STREET ADDRESS 6614 Belner Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Roland E. Parker, Jr. | | | 4. DATE OF DEATH July 16, 1967 Month July Day 16 Year 19 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 12, 1949 | | 9. AGE (In years last birthday) 17 yrs. | IF UNOER 1 YEAR Months 1 Days 1 | IF UNOER 24 HRS. Hours 1 Min. 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Flaparty Bros | | 10b. KIND OF BUSINESS OR INDUSTRY Storm doors | | 11. BIRTHPLACE (State or foreign country) Washington D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Roland E. Parker Sr. | | | | 14. MOTHER'S MAIDEN NAME Isabelle M. Flaherty | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 8254 | | 17. INFORMANT Isabelle M. Flaherty Parker Address Prince George's, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Crush Injuries to Head and Chest DUE TO (b) Automobile Accident DUE TO (c) Automobile Accident Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8254 |
| PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident (Passenger) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 1 Hour a.m. July 16 67 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> et work et work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Marlboro Pile | | 20f. (City or town) (County) (State) Prince George's, Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> July 16, 1967 M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (Acting) Address (Street, city, town, or county) Cheverly, Md. | | | | | | | 22. DATE SIGNED |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 19, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION (City, town or county) (State) Clinton, Maryland. | |
| 24. FUNERAL DIRECTOR 1661- Good Hope Road SE, Washington, DC | | | | 25a. REC'D BY REGISTRAR JUL 19 1967 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | |

MEDICAL CERTIFICATION

10028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Prince George's

Prince George's

Silver Hill

Chesley

Gold Branch Lane

Prince George's General Hospital

July 10, 1967

Rolland E. Barker, Jr.

17

White

Passive Crash Injuries to Head and Neck

Automobile Accident

Automobile Accident (Passenger)

Prince George's, Maryland

Harford Hill

July 10, 67

July 10, 1967

(Initials)

Richard J. Brown, MD

Chesley, R.

July 10, 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10029

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2a,c & d Film #G391 7/27/67 ph

CERTIFICATE OF DEATH

10031

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> D.C. b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> | | c. LENGTH OF STAY IN lb <u>5 years</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | | 473 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suitland Nursing Home</u> | | d. STREET ADDRESS <u>S.E. 730 1/2 13th St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Mary E. Pennington</u> | | 4. DATE OF DEATH <u>July 17 1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 17 - 1887</u> |
| 9. AGE (In years lost birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Nathan Graham</u> | | 14. MOTHER'S MAIDEN NAME <u>unk</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>H. G. Pennington (son)</u> | | Address <u>2403 Pershing Dr SE</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Thrombosis with</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Left hemiplegia due to hypertension</u> DUE TO (c) <u>arteriosclerotic Vascular disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 years and 5 mos.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/24/67</u> , 19 <u>67</u> , to <u>7/17/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/17</u> , 19 <u>67</u> , and that death occurred at <u>11:00 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Wm C. Lambert</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Wm C. LAMBERT</u> | | 22d. ADDRESS <u>2932 W. Street, S.E. DC 20</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 20 - 67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Summons Bros</u> | | 25a. REC'D BY REGISTRAR <u>APL 20 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

10053

10053

CHANGING MATHS HOURS

10053

10053

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--------------------------------------|--|---|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 10030 | | | | | | 10032 | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGES | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB | | | | c. LENGTH OF STAY IN 1b 6 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC 20027 HILLSIDE | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | | | | | d. STREET ADDRESS 1211 61st AVENUE | | | | | |
| 3. NAME OF DECEASED (Type or print) First ANNIE Middle E Last POINDEXTER | | | | | | 4. DATE OF DEATH Month JULY Day 29 Year 1967 | | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE CAU | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11 MAY 1919 | | 9. AGE (In years lost birthday) 48 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY NA | | 11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGES, MD. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOHN CHANEY | | | | | | 14. MOTHER'S MAIDEN NAME NETTIE PARKER | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 220-03-6990 | | 17. INFORMANT Address Same as #2 Katherine M. Beard (Sister) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ATHEROSCLEROSIS DUE TO (c) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 HRS 6 DAYS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (x) (this hospital) attended the deceased from 24 Jul , 19 67 , to 29 Jul , 19 67 , that (x) (we) last saw the deceased alive on 29 Jul , 19 67 , and that death occurred at 9:00 AM from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <i>Herbert Dardik</i> | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 29 July 67 | | | |
| 22c. PHYSICIAN'S NAME (Type) HERBERT DARDIK, CAPT USAF MC Andrews AFB, Washington DC | | | | | | 22d. ADDRESS USAF Hospital Andrews | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-2-1967 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Suitland Maryland | | | | | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland | | | | | | 25a. REC'D BY REGISTRAR DATE AUG 3 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

10000

ATTACHMENT OF DEATH

PRINCE GEORGES

1 DAY

USAF HOSPITAL ANDREWS

1711 GIST AVENUE

WHITE

11 MAY 1918

CAN

HOUSEWIFE

WA

PRINCE GEORGES, MD. USA

JOHN CHANEY

WITTIE PAPER

230-08-8990 KENNEDY, N. RAY (Sister)

CO-RECTIVE HEART FAILURE

ATHEROSCLEROSIS

PM

4308 Salsburg Road - Baltimore, Maryland
Robert E. Wilhelm Funeral Home

Initial

1-7-1967

Local 141 Cemetery

Beltsville

Maryland

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10031

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10033

| | | | | | | | |
|--|----------------------------------|---|---|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b DOA | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville 16.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS 3702 Farland Road | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Frank Middle I Last Poole | | | | 4. DATE OF DEATH Month 7 Day 27 Year 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11 Jan. 1906 | | 9. AGE (In years lost birthday) yrs. 61 | 10. IF UNDER 1 YEAR Months 7 Days 27 Hours 19 Min. 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATIONERY ENGINEER CHILDRENS HOSPITAL TRANCER, PA | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) PA | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME FRANK I POOLE | | | | 14. MOTHER'S MAIDEN NAME DELPHIA ANSEL | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 212-05-2124 | | 17. INFORMANT BIRDIE A POOLE | | Address #2 ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county) 7-28-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 7/31/67 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem | | 23d. LOCATION (City or Town) (County) (State) Baltimore Md | |
| 24. FUNERAL DIRECTOR W. W. Danielson Laurel Md. | | | | 25a. REC'D BY REGISTRAR AUG 1 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>Item 20 Film 391 8-2-67</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>10032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10034</div> | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i> c. LENGTH OF STAY IN 1b <i>DOA</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges</i> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Pr Geo</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carmody Hills</i> 16-1 d. STREET ADDRESS <i>7421 Blaine St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>DANIEL MARTIN PUGH</i> First Middle Last 5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>Aug 24 1950</i> 16 yrs. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 4. DATE OF DEATH <i>July 8</i> 19 <i>67</i> Month Day Year 9. AGE (In years, last birthday) <i>16</i> yrs. IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Helper</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i> 11. BIRTHPLACE (State or foreign country) <i>DC</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 13. FATHER'S NAME <i>Joseph Pugh</i> 14. MOTHER'S MAIDEN NAME <i>Estelle Hutchison</i> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <i>579-68-5784</i> 17. INFORMANT <i>Estelle Pugh</i> Address <i>7421 Blaine St Carmody Hills Md</i> | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>823.4</i> Massive Skull Fracture, right fronto-parietal DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>Trauma (Automobile Accident)</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Driving at high rate of speed in a stolen car - hit utility pole.</i> 20c. TIME OF INJURY Month, Day, Year <i>2:30</i> Hour <i>7-8</i> a.m. <i>1967</i> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i> 20f. (City or town) (County) (State) <i>Carmody Hills P.G. Md.</i> | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Dayton Watkins</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>7-8-67</i> EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <i>531 8th Ave Rd</i> 22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Bladensburg Md</i> Address (Street, city, town, or county) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>July 11, 1967</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i> 23d. LOCATION (City, town or county) (State) <i>Washington, D. C.</i> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>F. Gasch & Sons</i> ADDRESS <i>Hyattsville, Maryland</i> 25a. REC'D BY REGISTRAR <i>JUL 12 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

100338

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

100335

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>PR. GEORGE'S</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P.G.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILESIA</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINE VIEW GARDENS</u> | | d. STREET ADDRESS <u>8671 Riverview Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES IRA RAUM</u> | | 4. DATE OF DEATH Month Day Year <u>7-1-1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-30-1897</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u> | 9. AGE (In years last birthday) <u>69</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country) <u>P.G., MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>WILLIAM F. RAUM</u> | | 14. MOTHER'S MAIDEN NAME <u>MARCELENA TAYLOR</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>579-18-6166</u> | |
| 17. INFORMANT <u>MILDRED RAUM, SILESIA, MD.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinomatoses</u> DUE TO (c) <u>from Bronchogenic Carcinoma</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-19-1967</u> to <u>7-1-1967</u> that (I) (we) last saw the deceased alive on <u>6-30-1967</u> and that death occurred at <u>8:40 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Alfred R. Lapin, MD.</u> | | 22b. DATE SIGNED <u>7-1-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN</u> | | 22d. ADDRESS <u>CLINTON, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>7-3-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>TRINITY MEMORIAL</u> | 23d. LOCATION (City or Town) (County) (State) <u>WALDORF, CHARLES MD.</u> |
| 24. FUNERAL DIRECTOR <u>HUNT FUNERAL HOME, WALDORF, MD.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 5 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10034

CERTIFICATE OF DEATH

10036

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | | c. LENGTH OF STAY IN 1b 12 days | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | | | d. STREET ADDRESS 612 F Street, N.E. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First George Middle B. Last Reed | | | | 4. DATE OF DEATH Month July Day 31 Year 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-28-1894 | 9. AGE (In years last birthday) 73 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - PAINTER | | 10b. KIND OF BUSINESS OR INDUSTRY PAINTING | | 11. BIRTHPLACE (County & State, or foreign country) Unknown WEST, VA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Lincoln Reed | | | | 14. MOTHER'S MAIDEN NAME Mary Cartwright | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 229-09-6414 | | 17. INFORMANT (Decedent) Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 mo. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/19/ , 19 67 , to 7/31/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/31/ , 19 67 , and that death occurred at 9:00AM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Moe Weiss | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 7/31/67 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-4-67 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Bladensburg Md | |
| 24. FUNERAL DIRECTOR W.W. Chambers Co | | | | ADDRESS 517-11th St SE | | 25a. REC'D BY REGISTRAR AUG 4 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10084

Glenn Dale (Vestal)

Glenn Dale (Vestal)

Glenn Dale (Vestal)

George

Male - White

Height - 180cm

Lincoln Road

Weight - 180lb

100-10-100 (100-10-100)

Glenn Dale (Vestal)

Glenn Dale (Vestal)

Glenn Dale (Vestal)

Glenn Dale (Vestal)

Glenn Dale (Vestal)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10035

CERTIFICATE OF DEATH

10037

| | | | | | | | |
|--|--------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base | | | | c. LENGTH OF STAY IN 1b 131 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First LOUIS Middle CARL Last REGALIA | | | | 4. DATE OF DEATH Month July Day 13 Year 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE Cau | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 14 Sep 10 | 9. AGE (In years lost birthday) 56 yrs. | IF UNDER 1 YEAR Months 56 Days 13 Hours 19 Min. | IF UNDER 24 HRS. Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Soldier | | | 10b. KIND OF BUSINESS OR INDUSTRY USAF | | 11. BIRTHPLACE (County & State, or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME N. P. Regalia | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) 1942-1963 | | 17. INFORMANT Wife | | Address same as item #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Esophagus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 150X DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) was attended the deceased from 3 March , 1967, to 13 July , 1967, that (I) was saw the deceased alive on 13 July , 1967, and that death occurred at 745a M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Frederick Sachs | | | | 22b. DATE SIGNED 13 July 1967 | | 22c. PHYSICIAN'S NAME (Type) FREDERICK SACHS, CAPT, USAF, MC USAFH, Andrews AFB, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7/18/67 | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON VA'S | | 23d. LOCATION (City or Town) (County) (State) ARLINGTON, Virginia | |
| 24. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md. | | | | 25a. REC'D BY REGISTRAR DATE JUL 17 1967 | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |

10032

STATEMENT OF DEATH

Prince Georges

Maryland

Prince Georges

Green Hill

1st day

USAF Hospital Andrews

1st day

July 13 1957

RECALL

HOUSE

19

1st day

KX

Male

USA

Italy

USA

Retired - Soldier

Unknown

W. F. Regalia

Wife

1943-1957

Yes

Continuation of the Report

July 13 1957

March 27 1957

March 27 1957

July 13 1957

USAF Hospital Andrews

W. F. Regalia, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10036

10038

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland | | c. LENGTH OF STAY IN 1b DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andrews Air Force Base Hospital | | d. STREET ADDRESS Rt3, Box 260C | |
| 3. NAME OF DECEASED (Type or print) First William Middle Preston Last Richards | | 4. DATE OF DEATH Month 7 Day 19 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 14 Aug. 1938 |
| 9. AGE (In years lost birthday) 28 yrs. | | 10. IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SP 5 US Army | | 10b. KIND OF BUSINESS OR INDUSTRY Army | |
| 11. BIRTHPLACE (State or foreign country) Washington, DC | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Preston Richards | | 14. MOTHER'S MAIDEN NAME Helen I. Rowlings | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. 212-38-8284 | |
| 17. INFORMANT Harriett W. Richards | | Address Brandywine, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging 977X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year after 6:00pm 7-18-1967 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county) | |
| 22. DATE SIGNED 7-20-67 | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/25/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia | |
| 24. FUNERAL DIRECTOR ADDRESS Falls Church Funeral Home, Falls Ch., Va. | | 25a. REC'D BY REGISTRAR JUL 27 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1608

Abstract

STATISTICAL SUMMARY

Figure 18. Schematic of the proposed mechanism for the formation of the β -phase in the Ti-6Al-4V alloy.

done in 1991

- 1 -

70 / 604

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

20 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10037

10039

| | | | | | | | |
|---|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 23 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 5205 Upshur Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Arthur S. Rogstad | | | | 4. DATE OF DEATH Month Day Year July 14 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/14/06 | | 9. AGE (In years last birthday) 61 1/2 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY C & P Telephone Co | | 11. BIRTHPLACE (County & State, or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Olaf Rogstad | | | | 14. MOTHER'S MAIDEN NAME Amanda Paulson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 05-6036500 | | 17. INFORMANT Helen J. Rogstad Address Bladensburg Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous to Brain DUE TO (b) Carcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 67 , to 7/14 , 19 67 , that (I) (we) last saw the deceased alive on 7/14 , 19 67 , and that death occurred at 7:30 A.M. , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Barry Rosenberg | | 22b. DATE SIGNED July 15 1967 | | 22c. PHYSICIAN'S NAME (Type) BARRY ROSENBERG | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 15 1967 | | 23c. NAME OF CEMETERY OR CREMATORY St. Francis Cemetery | | 23d. LOCATION (City or Town) (County) (State) College Manor Md | |
| 24. FUNERAL DIRECTOR Willy Funeral Home | | ADDRESS McLean Md | | 25a. RECD BY REGISTRAR JUL 18 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

10035

STATE OF TEXAS

County of ... State of Texas

Know all men by these presents, that ...

for and to the use of ...

in witness whereof ...

Given under my hand and seal of office ...

at the City of ... this ... day of ...

19... A.D. 19...

Notary Public in and for the State of Texas

My commission expires ...

Witness my hand and seal of office ...

at the City of ... this ... day of ...

19... A.D. 19...

Notary Public in and for the State of Texas

My commission expires ...

Witness my hand and seal of office ...

at the City of ... this ... day of ...

19... A.D. 19...

Notary Public in and for the State of Texas

My commission expires ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

10038

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10049

| | | | | | | | |
|---|------------------------------|---|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md</u> | | c. LENGTH OF STAY IN 1b <u>Feb. 63.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood, Md</u> | | 161 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyatts ville Nursing Home</u> | | | | d. STREET ADDRESS <u>3708-37th place</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ELENA ROSA</u> <u>Rosenfield</u> | | | | 4. DATE OF DEATH Month Day Year <u>July</u> <u>4</u> <u>1967</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/8/1886</u> | 9. AGE (In years last birthday) <u>81 yrs.</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Mass. Lawrence</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Cornelius Hagelberty</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Harrington</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217-14-7117-D</u> | | 17. INFORMANT <u>Miss F. Rosenfield</u> Address <u>Brentwood, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3-5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>July</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 3</u> , 19 <u>67</u> , and that death occurred at <u>4:45 A.M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Myron L. Lenku</u> | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) <u>2309 Shorewood Wheaton Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/6/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u> | | | | 25a. REC'D BY REGISTRAR <u>DATE JUL 7 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u> | |

1038

7

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
35DD 4-64

10039

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10041

| | | | | | | | |
|--|-------------------------------------|---|-------------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, b. COUNTY D.C. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b D.O.A. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | e. STREET ADDRESS 1825 T St. N.W. | | | |
| 3. NAME OF DECEASED (Type or print) Hiroshi Frederick Saito | | | | 4. DATE OF DEATH Month July Day 16 Year 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE Oriental | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-15-33 | 9. AGE (In years last birthday) 33 yrs. | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 24 HRS. Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt. | | 11. BIRTHPLACE (State or foreign country) Californina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Yoshio Saito | | | | 14. MOTHER'S MAIDEN NAME Fumi Hattori | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Park Police | | | |
| | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Chest and Head Crush Injuries 8254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Automobile accident DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:02 pm 7/16 1967 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B&W Parkway | | 20f. (City or town) (County) (State) Cheverly, Prince Georges, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>Cornelius H. Burns</i> | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>(At ing)</i> | | 22. DATE SIGNED 7/16/67 | |
| EXAMINER'S NAME (Type) Cornelius H. Burns, M.D. | | | | Address (Street, city, town, or county) Cheverly, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 7-18-67 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d. LOCATION (City, town or county) (State) Washington, D.C. | |
| 24. FUNERAL DIRECTOR Lee Funeral Home | | | | ADDRESS Washington, D.C. | | 25. REG'D BY REGISTRAR JUL 20 1967 | |
| | | | | DATE | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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• **Let's Go!**

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10040

CERTIFICATE OF DEATH

10042

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Lanham</u> c. LENGTH OF STAY in 1b <u>60 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C. Md.</u> b. COUNTY <u>Prince Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham Maryland</u> d. STREET ADDRESS <u>Railroad Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Lillian Plater Sanders</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital Aid</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u> 13. FATHER'S NAME <u>Robert Fletcher</u> | | | 4. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>1967</u> 8. DATE OF BIRTH <u>2/21/01</u> 9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> 14. MOTHER'S MAIDEN NAME <u>Mamie Jones</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Madame Rd</u> <u>Frances Hawkins 9111 Utica Pl.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>1992</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/23/67</u> , to <u>7/23/67</u> , that (I) (we) last saw the deceased alive on <u>7/23</u> 19 <u>67</u> and that death occurred at <u>7/23</u> M, from causes and on the date stated above. 22a. SIGNATURE <u>Henry A. Wise Jr</u> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>Henry A. Wise Jr</u> 22d. ADDRESS <u>Lanham, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF <u>7-27-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cem.</u> 23d. LOCATION (City or Town) (County) (State) <u>Washington DC</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>H.S. Washington & Son 4925 Adams Ave NE</u> 25a. REC'D BY REGISTRAR <u>Charles Jones</u> 25b. REGISTRAR'S SIGNATURE DATE <u>JUL 27 1967</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

02001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10041

10043

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>V.G.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton Md.</u> | | | | c. LENGTH OF STAY IN 1b <u>2 Mcs.</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER MARLBORO</u> | | | | 10.1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Care Center, Clinton Md.</u> | | | | d. STREET ADDRESS <u>1239 Old Marlboro Pike</u> | | | |
| e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>George</u> First <u>H</u> Middle <u>Schlorb</u> Last <u>TR</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1967</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH <u>5-30-1898</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER RETIRED GRAVE DIGGER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George L. Schlorb</u> | | | | 14. MOTHER'S MAIDEN NAME <u>DONALDSON</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>577-22-7257</u> | | 17. INFORMANT <u>LILLIE E SCHLORB</u> Address <u>SAME AS 2D</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebratory Collapse</u> DUE TO <u>Multiple Emboli</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Hypertensive Disease</u> (c) <u>3 yrs.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from <u>6-23</u> , 19 <u>67</u> , to <u>7-22</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>7-22</u> , 19 <u>67</u> , and that death occurred at <u>4:15 PM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Alfred R. Lapin, M.D.</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u> | | | | 22d. ADDRESS <u>Clinton, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>DEATH</u> | | 23b. DATE THEREOF <u>7-27-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM</u> | | 23d. LOCATION (City or Town) (County) (State) <u>SUITLAND MD</u> | |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers & Co. 517-11th St SE Wash D.C.</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 27 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>g Charles Judge</u> | |

10041

TEST DATE OF DEATH

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "July" and "1941" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10042

CERTIFICATE OF DEATH

10044

| | | | |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>P. Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> | | c. LENGTH OF STAY IN 1b <u>24 hrs.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Conn. Home</u> | | d. STREET ADDRESS <u>323 Laurel Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Scott</u> Last <u>Scott</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 9, 1879</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles Duvall</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah A. Boone</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT <u>Nursing home records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vas. accident</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Zenithal Pneumonia</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>15 yrs</u> <u>2 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1940</u> to <u>7/21</u> , 1967 that (I) (we) lost saw the deceased alive on <u>7/21</u> , 1967, and that death occurred at <u>10:30 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>B P Warren</u> M.D. | | 22b. DATE SIGNED <u>7/21/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>B P Warren</u> | | 22d. ADDRESS <u>Laurel Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>7-24-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Headsprings Memorial Park</u> | 23d. LOCATION (City or Town) (County) (State) <u>Laurel Md</u> |
| 24. FUNERAL DIRECTOR <u>Walter Connelly</u> | | 25a. REC'D BY REGISTRAR DATE <u>JUL 31 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u> | | | |

2025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

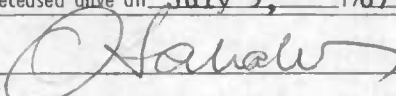
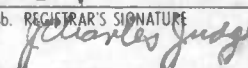
10042

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 11, 12, 13 & 14 Film 390 7/17/67 kk

CERTIFICATE OF DEATH

10045

| | | | | | | | |
|---|----------------------------------|---|---------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 11 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellviller 161 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | d. STREET ADDRESS Route 301 | | | |
| 3. NAME OF DECEASED (Type or print) Margaret First Middle Last Scrivner | | | | 4. DATE OF DEATH July 9 1967 Month Day Year | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1907 | 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Henderson Jenkins | | | | 14. MOTHER'S MAIDEN NAME Julia Ford | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from June 29, 1967 , to July 9, 1967 , that (X) (we) last saw the deceased alive on July 9, 1967 , and that death occurred at 7:10 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE  Ohannes Sahakyan, M. D. | | | | 22b. DATE SIGNED July 10, 1967 | | 22c. PHYSICIAN'S NAME (Type) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7.13.67 | | 23c. NAME OF CEMETERY OR CREMATORY HARMONY | | 23d. LOCATION (City or Town) (County) (State) MARYLAND | |
| 24. FUNERAL DIRECTOR V. Kerner | | | | 25a. REC'D BY REGISTRAR DATE JUL 12 1967 | | 25b. REGISTRAR'S SIGNATURE  | |

10049

Police Records

University

11 days

Michigan

Police Records

Michigan

Michigan

Michigan

July

1907

1907

Police Records

Police Records

Police Records

Michigan

Michigan

Michigan

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10044

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harmont Heights</u> | |
| c. LENGTH OF STAY IN 1b <u>DOA</u> | | d. STREET ADDRESS <u>700-59 ave</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General</u> | | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>RICHARD</u> | First Middle Last <u>SHAW</u> | 4. DATE OF DEATH <u>July 8</u> 19 <u>67</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/13/20</u> 9. AGE (In years, last birthday) <u>47</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Frank Shaw</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary A. Jones</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Ronnie Shaw</u> | | Address <u>714 SHAW RD FAYETTEVILLE N.C.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>1. Cardiac Thompsonade</u> 982X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>2. Penetrating wound Rt ventricle</u> DUE TO (c) <u>3. Stab wound of left antecubital chest</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-9-67 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 5318 Annapolis DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED Address (Street, city, town, or county) <u>Bloomington</u> | |
| ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D. | | EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE THEREOF <u>7-13-67</u> | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) <u>FAYETTEVILLE N.C.</u> |
| 24. FUNERAL DIRECTOR <u>B. E. Kipler</u> ADDRESS <u>909 6th St N.W. D.C.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 13 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jago</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11457

CERTIFICATE OF DEATH

11462

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN TB 23 hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Baby Boy Shugard | | 4. DATE OF DEATH Month Day Year July 31 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 30 July 1967 |
| 9. AGE (In years last birthday) 23 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | |
| 13. FATHER'S NAME Michael | | 14. MOTHER'S MAIDEN NAME Sharon Grover | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 17. INFORMANT Sharon Grover | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7573 IMMEDIATE CAUSE (a) Prematurity DUE TO (b) atelectasis, bi-lateral DUE TO (c) Horse shoe Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 30, 1967 , to July 31, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 31, 1967 , and that death occurred 12, 10 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Patrick A. Reardon | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Patrick A. Reardon, M. D. | | 22d. ADDRESS Prince Georges General Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE THEREOF 8/5/67 | 23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. | 23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland |
| 24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 3 1967 | 25b. REGISTRAR'S SIGNATURE Charles Judge |

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

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Prison Commission

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10046

Item 8 Film G350 1711/67 KK

CERTIFICATE OF DEATH

10048

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Med Examiner Notary and approved by Justice

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia, P.C.</u> b. COUNTY <u>Washington, D.C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> | |
| c. LENGTH OF STAY in 1b <u>1 day</u> | | d. STREET ADDRESS <u>5202 N St. S.E.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Md. Medical Center.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>ORA.</u> Middle <u>M.</u> Last <u>Sibley</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/28/02</u> 9. AGE (In years last birthday) <u>65</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>TALIHINIA, OAK</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>John McGee</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Lillie King</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>NONE</u> | |
| 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT Address <u>Jack Byron Powell Rt 2 Woodbine Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Renal Disease</u> DUE TO (c) <u>Hypertensive Disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 15</u> , 19 <u>67</u> , to <u>7-6</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7-6-67</u> 19 <u>67</u> and that death occurred at <u>4:15</u> P.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Alfred R. Lavin</u> M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAVIN</u> | | 22d. ADDRESS <u>CLINTON, MD.</u> | |
| 23a. BURIAL, CREMATION, or other disposition <u>BURIAL</u> | 23b. DATE THEREOF <u>7-10-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | 23d. LOCATION (City or town) (County) (State) <u>Rockville Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u> | | 25a. REC'D BY REGISTRAR <u>JUL 10 1967</u> DATE | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

10046

INVESTIGATION OF THE DEPARTMENT OF JUSTICE
DIVISION OF INVESTIGATION - FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C.

Washington, D.C.

June 10, 1964

Mr. J. Edgar Hoover

Director, FBI

Re: [illegible]

Enclosed for the Bureau are

three copies of a letterhead

transmission dated and captioned

as above.

Very truly yours,

[illegible signature]

Special Agent in Charge

[illegible name]

Enclosure

cc - [illegible]

cc - [illegible]

cc - [illegible]

cc - [illegible]

cc - [illegible]

cc - [illegible]

cc - [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10047

CERTIFICATE OF DEATH

10049

| | | | | | | | |
|--|----------------------------------|--|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY in lb 2 1/2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | d. STREET ADDRESS Box 2745 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Margaret Irma XX Simpson | | | | 4. DATE OF DEATH Month Day Year July 31, 19 67 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> SEPARATED <input type="checkbox"/> | 8. DATE OF BIRTH May 23, 1913 | | 9. AGE (In years last birthday) 54 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Thomas Perry White | | | | 14. MOTHER'S MAIDEN NAME Maggie Boteler | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Address Ralph M. Simpson-Same as Item #2. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Cardiac Arrest DUE TO (c) Myocardial Hypotrophy | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from July 29, 1967 , to July 31, 1967 , that (X) (we) last saw the deceased alive on July 31, 1967 , and that death occurred at 10:40 AM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D. AM | | 22b. DATE SIGNED 7/31/67 | |
| 22c. PHYSICIAN'S NAME (Type) Tomas Hernandez, M. D. | | | | 22d. ADDRESS Cheverly, Md. Prince Georges General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/2/67 | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery | | 23d. LOCATION (City or Town) (County) (State) Upper Marlboro, Md. | |
| 24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Fun'l Home-Upper Marlboro, Md. | | | | 25a. REC'D BY REGISTRAR DATE AUG 4 1967 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

10047

CERTIFICATE OF DEATH

Trinity Cemetery
Upper Marlboro
1/2 days

Trinity Cemetery
Upper Marlboro

Trinity Cemetery
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FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10048

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10050

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Hills | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Hills 16-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4007 Tennyson Street | | | | d. STREET ADDRESS 4007 Tennyson Street | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Daniel Todd Sloan | | | | 4. DATE OF DEATH Month Day Year 7 22 1967 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2-24-06 | |
| 9. AGE (In years last birthday) 61 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | 10. AGE (In years last birthday) 61 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker G..P.O. | | | | 10b. KIND OF BUSINESS OR INDUSTRY G..P.O. | | | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Frank J. Sloan | | | | 14. MOTHER'S MAIDEN NAME Martha Burke | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes End War | | | | 16. SOCIAL SECURITY NO. 215-44-8522 | | | |
| 17. INFORMANT Dorothy H. Sloan (Wife) | | | | Address 4007 Tennyson Univ. Park, Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary failure 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary emphysema DUE TO (c) _____ over 10 yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | | | |
| 22. DATE SIGNED 7-22-67 | | | | 22. DATE SIGNED 7-22-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 7-26-67 | | 23c. NAME OF CEMETERY OR CREMATORY St. Lincolns | |
| 23d. LOCATION (City or Town) (County) (State) College Manor, Md. | | | | 23d. LOCATION (City or Town) (County) (State) College Manor, Md. | | | |
| 24. FUNERAL DIRECTOR J. Wm. Lee & Sons | | | | 25a. REC'D BY REGISTRAR JUL 27 1967 | | | |
| 25b. REGISTRAR'S SIGNATURE y Charles Judge | | | | 25b. REGISTRAR'S SIGNATURE y Charles Judge | | | |
| 25c. ADDRESS 4th & Mass Ave Washington, D.C. | | | | 25c. ADDRESS 4th & Mass Ave Washington, D.C. | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prnce Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Hyattsville d. STREET ADDRESS 2217 University Blvd., E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Joseph Vincent Smith | | 4. DATE OF DEATH Month Day Year July 21, 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 16, 1902 |
| 9. AGE (In years last birthday) 70 | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. | |
| 11. BIRTHPLACE (County & State, or foreign country) Pittsburg, Penna. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Smith | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. 209-10-9564 | |
| 17. INFORMANT Hilda Smith | | Address 2217 University Blvd. E. Silver Spring, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis generalized DUE TO (c) 6 months | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (the hospital) attended the deceased from 1955 , 19 to July 21, 1967 , that (I) (we) last saw the deceased alive on July 21, 1967 , and that death occurred at 9:55 A. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Leon R. Levitsky, M. D. | | 22b. DATE SIGNED 7-21-67 | |
| 22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M. D. | | 22d. ADDRESS 3408 Rhode Island Ave. Mt. Rainier, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial | 23b. DATE THEREOF July 25, 1967 | 23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | 23d. LOCATION (City or town) (County) (State) Pittsburg, Penna. |
| 24a. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. | | 25a. REC'D BY REGISTRAR JUL 25 1967 | |
| 24b. ADDRESS 8434 Georgia Avenue Silver Spring, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | |
|--------------------|--|--------|--|-----|--|---------------|--|----------------|--|--------------|--|----------|--|----------|--|
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| John A. Smith | | Male | | 25 | | Jan 15 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Mary E. Smith | | Female | | 23 | | Feb 10 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Robert L. Smith | | Male | | 22 | | Mar 5 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Elizabeth A. Smith | | Female | | 21 | | Apr 1 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| William H. Smith | | Male | | 20 | | May 1 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Margaret M. Smith | | Female | | 19 | | Jun 1 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Charles F. Smith | | Male | | 18 | | Jul 1 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Anna D. Smith | | Female | | 17 | | Aug 1 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Frank J. Smith | | Male | | 16 | | Sep 1 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Helen K. Smith | | Female | | 15 | | Oct 1 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| George W. Smith | | Male | | 14 | | Nov 1 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Alice L. Smith | | Female | | 13 | | Dec 1 1900 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Edward G. Smith | | Male | | 12 | | Jan 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Bertha H. Smith | | Female | | 11 | | Feb 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| John B. Smith | | Male | | 10 | | Mar 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Mary C. Smith | | Female | | 9 | | Apr 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| William D. Smith | | Male | | 8 | | May 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Elizabeth E. Smith | | Female | | 7 | | Jun 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Frank I. Smith | | Male | | 6 | | Jul 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Alice J. Smith | | Female | | 5 | | Aug 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| George K. Smith | | Male | | 4 | | Sep 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Helen L. Smith | | Female | | 3 | | Oct 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| John M. Smith | | Male | | 2 | | Nov 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| Mary N. Smith | | Female | | 1 | | Dec 1 1901 | | New York City | | New York | | New York | | New York | |
| Name of Person | | Sex | | Age | | Date of Birth | | Place of Birth | | Municipality | | County | | State | |
| William O. Smith | | Male | | 0 | | Jan 1 1902 | | New York City | | New York | | New York | | New York | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

FOR STATE
HEALTH DEPT.

10050

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10052

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|---------------------------------|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md. c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights d. STREET ADDRESS 7727 Walter Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Charles P. Snipes | | 4. DATE OF DEATH July 16 19 67 | | 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/10/49 | | 9. AGE (In years last birthday) 18 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 13. FATHER'S NAME Howard M. Snipes, Jr. | | | | 14. MOTHER'S MAIDEN NAME Archie C. Tasker | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Archie C. Snipes, mother | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Crush Injuries to Chest and Head 8254 DUE TO Automobile accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:00 x 7/16 19 67 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Marlboro Pike | | 20f. (City or town) Prince George's, Md. | | (County) | | (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | 22. DATE SIGNED 7/16/67 | | | | | | | |
| ACTUAL SIGNATURE Cornelius J. Burns | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER XXX (Acting) | | | | 22. DATE SIGNED 7/16/67 | | | | | | | |
| EXAMINER'S NAME (Type) Cornelius J. Burns, M.D. | | | | Address (Street, city, town, or county) Cheverly, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 19, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City, town or county) Suitland, Maryland | | (State) | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR 1661- Good Hope Road SE. Wash., DC | | | | 25a. REC'D BY REGISTRAR JUL 19 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | |

100-100000

Prince George's

Station

Prince George's

Station

Station

7777

Prince George's

July 10

Station

Charles

Male

Female

Prince George's

Station

Automatic

Prince George's

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Station

July 10

Station

Station

Station

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July 10

Station

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10051

10053

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>WASH MD - DC</u> b. COUNTY <u>P.G.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> | | c. LENGTH OF STAY IN It <u>24 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINEVIEW GARDENS</u> | | d. STREET ADDRESS <u>12314 Old Fort Rd</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>LUCILLE</u> Middle <u>SNOWDEN</u> Last <u>SNOWDEN</u> | | 4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-8-02</u> |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN OF SCHOOL</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Chapel Hill Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James Henry Shorter</u> | | 14. MOTHER'S MAIDEN NAME <u>Clara Woodland</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u> </u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac-Respiratory Collapse</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast</u> DUE TO (c) <u>with Metastases</u> | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) <u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-7</u> , 19 <u>67</u> , to <u>7-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-24</u> , 19 <u>67</u> , and that death occurred at <u>11:45</u> AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Alfred R. Lapin</u> M.D. | | 22b. DATE SIGNED <u> </u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, MD</u> | | 22d. ADDRESS <u>CLINTON, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>7-28-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist Ch Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Chapel Hill, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>John T. Rhines</u> | | 25a. REC'D BY REGISTRAR DATE <u>AUG 3 1967</u> | |
| ADDRESS <u>3015-12th St NE</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

Wash DC

10023

UNIT CASE OF DEATH

UNIT CASE OF DEATH

UNIT CASE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10052

CERTIFICATE OF DEATH

10054

| | | | | | | | |
|---|---------------------------------|--|---------------------------------|--|--------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 1 Hr. 15 mins. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 6107 Jay Street | | | |
| 3. NAME OF DECEASED (Type or print) Baby Girl First Middle Last Stewart | | | | 4. DATE OF DEATH July 14, 1967 Month Day Year | | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/14/67 | 9. AGE (In years lost birthday) yrs. 16-1 | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. 15 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Geraldine (Ball) Stewart | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral atelectasis DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that he (this hospital) attended the deceased from 7/14 , 19 67 to 7/14 , 19 67 that he (we) lost saw the deceased alive on 7/14 19 67 , and that death occurred at 11:05 , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE P. A. Reardon | | | | A.M. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 7-18-67 | |
| 22c. PHYSICIAN'S NAME (Type) P. A. Reardon, M. D. | | | | 22d. ADDRESS Prince Georges General Hospital, Cheverly | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) cremation | | 23b. DATE THEREOF 7/22/67 | | 23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. | | 23d. LOCATION (City or Town) (County) Cheverly Md. Maryland | |
| 24. FUNERAL DIRECTOR Harry W. Penn, Jr., Administrator | | | | 25a. REC'D BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| | | | | DATE JUL 26 1967 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10052

CERTIFICATE OF DEATH

10055

| | | | | | | | |
|--|----------------------------------|---|---|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST HEIGHTS | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST HEIGHTS | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) #13 BLACKHAWK DRIVE | | | | d. STREET ADDRESS # 13 BLACKHAWK DRIVE | | | |
| 3. NAME OF DECEASED (Type or print) First AGNES Middle C. Last STONE | | | | 4. DATE OF DEATH Month JULY Day 5 Year 19 67 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT. 14, 1909 | 9. AGE (In years last birthday) 57 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | IF UNDER 24 HRS Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) KENTUCKY | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ANTHONY HUSER | | | | 14. MOTHER'S MAIDEN NAME ANNE ERDHAUS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ELIZABETH MC DOUGALL Address SAME AS # 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure DUE TO (b) 1. Labor Pains DUE TO (c) 2. Metastatic carcinoma of kidney PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 dy. no spec. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan, 1962 , to Jul, 5, 1967 , that (I) (we) lost saw the deceased alive on Jul, 5, 1967 , and that death occurred at 10:55 A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE B. Bahrami | | | | 22b. DATE SIGNED Jul, 5, 1967 | | 22c. PHYSICIAN'S NAME (Type) B. BAHRAMI, M.D. | |
| 22d. ADDRESS 3003 Naylor Rd, SE, Wash DC | | | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22f. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7/8/67 | | 23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEMETERY | | 23d. LOCATION (City or Town) (County) (State) PRINCE GEORGES, MARYLAND | |
| 24. FUNERAL DIRECTOR ROBERT E. WILHELM ADDRESS 4308 SUITLAND ROAD, SUITLAND, MARYLAND | | | | 25a. REC'D BY REGISTRAR JUL 7 1967 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

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#18per hospital 9/28/83 kam

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH YEAR 7b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Michael James Stump | | | July 11, 1967 | | 11:30A M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 11, 1967 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 30 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD |
| 10. CITY OR TOWN OF DEATH Cheverly | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Infant | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY P.G. | 13c. CITY OR TOWN Lanham | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Fearis Stump | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bonnie Ella Luebcke | | 13e. STREET ADDRESS / ZIP CODE 12014 Lanham Severn Rd. 20706 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Probable Stillbirth</u> 7955 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Premature labor</u> | | | | | 1 hr |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Birth occurred at home - Infant D.O.A. according to records</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-11</u> , 19 <u>67</u> , to <u>7-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>D.O.A.</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>R.D. Bauer M.D.</u> | | DEGREE <u>M.D.</u> | | 22c. DATE SIGNED <u>9-21-83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R.D. Bauer, M.D.</u> | | 22e. ADDRESS <u>Prince George's General Hospital, Cheverly, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremated</u> | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 24. FUNERAL DIRECTOR NAME P.G. Hospital ADDRESS | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>John J. Lauer</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10054

CERTIFICATE OF DEATH

10056

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence at time of death, if not) a. STATE <i>New Jersey</i> b. COUNTY <i>Hudson</i> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CLINTON, MARYLAND</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jersey City</i> | |
| c. LENGTH OF STAY IN 1b <i>10 days</i> | | d. STREET ADDRESS <i>37 Bidwell Ave.,</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Gene View Gardens Nursing Home</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>A.</i> Last <i>SULLIVAN</i> | | 4. DATE OF DEATH Month <i>July</i> Day <i>17</i> Year <i>1967</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Feb. 6 - 1888</i> |
| 9. AGE (In years last birthday) <i>79</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | |
| 11. BIRTHPLACE (County & State, or foreign country) <i>Jersey City, N.J.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Luke B. Ford</i> | | 14. MOTHER'S MAIDEN NAME <i>Sarah E. Tanner</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>0</i> | |
| 17. INFORMANT <i>Francis Buckingham</i> | | Address <i>Rt. 2, Box 186 Brandywine, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Collapse</i> DUE TO (b) <i>multiple emboli - vascular</i> DUE TO (c) <i>arteriosclerotic hypertension disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>7-7</i> , 19 <i>67</i> to <i>7-17</i> , 19 <i>67</i> ; that (I) (we) last saw the deceased alive on <i>7-17</i> , 19 <i>67</i> , and that death occurred at <i>6:50</i> A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Alfred R. Lapin</i> | | 22b. DATE SIGNED <i>7-17-67</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPIN, MD</i> | | 22d. ADDRESS <i>CLINTON, MD.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE THEREOF <i>7/20/67</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Holy Name Cath. Cem.</i> | 23d. LOCATION (City or Town) (County) (State) <i>Jersey City, N.J.</i> |
| 24. FUNERAL DIRECTOR <i>Ritchie Bros. Upper Marlboro, Md.</i> | | 25a. REC'D BY REGISTRAR <i>JUL 21 1967</i> | |
| | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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NEW JERSEY

JERSEY CITY

21 BROADWAY

NEW JERSEY

HOME

NEW JERSEY

CLINTON, N. Y.

NEW JERSEY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #4 Film #G390 7/11/67 ps

10055

CERTIFICATE OF DEATH

10057

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLSIDE</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINE VIEW NURSING HOME</u> | | | | d. STREET ADDRESS <u>5800 M-ST</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Wallace Talbert</u> | | | | 4. DATE OF DEATH Month Day Year <u>7 3 1967</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-18-1891</u> | |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED NIGHT WATCHMAN</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>JAMES J TALBERT</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARGARET BROWN</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>578-03-9257</u> | | 17. INFORMANT Address <u>3024 SILVER HILL GAIT SUITLAND</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO <u>Arteriosclerotic Heart Disease 3 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility Syndrome</u> (c) <u>Senility Syndrome</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/14</u> , 19 <u>67</u> , at <u>7-30</u> AM, that (I) (we) last saw the deceased on <u>4/13</u> , 19 <u>67</u> , and that death occurred at <u>5:03</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Alfred R. Lapin</u> M.D. | | | | 22b. DATE SIGNED <u>7-3-1967</u> | | 22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN</u> | |
| 22d. ADDRESS <u>CLINTON, MD</u> | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>7-6-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>WASH NATL CEM</u> | | 23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD</u> | |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

32003

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10056

10058

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville c. LENGTH OF STAY IN b 16-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4909 Smithwick Lane | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville d. STREET ADDRESS 4909 Smithwick Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) NONA LEE BESS TROUTT First Middle Last | | 4. DATE OF DEATH July 8, 1967 Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 20, 1891 yrs. Months Days |
| 9. AGE (In years last birthday) 76 | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Tenn. | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME ? Howell | | 14. MOTHER'S MAIDEN NAME Harriett E. Cole | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. 412-12-8394 | |
| 17. INFORMANT Mrs Mary E. Chance- Item # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Myocardial infarction. 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) ② Angerative heart failure DUE TO (c) ③ Atherosclerotic heart disease | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While Not While at work at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from here , 19 66 to July 8 , 19 67 , that (I) (we) last saw the deceased alive on 7/8/67 , 19 67 , and that death occurred at 9⁰⁰ AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Benjamin Maldonado Jr. 22c. PHYSICIAN'S NAME (Type) BENJAMIN MALDONADO JR M.D. | | 22b. DATE SIGNED 7/8/67 22d. ADDRESS 3308 Dodge Park Rd. LANDOVER MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit | | 23b. DATE THEREOF 7/9/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery | | 23d. LOCATION (City, town or county) (State) Memphis, Tenn. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS Rockville Home-1331 Rockville Pike Rockville, Maryland | | 25a. REC'D BY REGISTRAR JUL 11 1967 25b. REGISTRAR'S SIGNATURE Charles Joyce | |

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Prince George

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

10057

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10059

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd. | | | | d. STREET ADDRESS 7402 Wellesley Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle Uher Last Uher | | | | 4. DATE OF DEATH Month July Day 23 Year 1967 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 26, 1889 | | 9. AGE (In years last birthday) yrs. 78 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Cleveland, Ohio | | 12. CITIZEN OF WHAT COUNTRY? United States | |
| 13. FATHER'S NAME Anton Svoboda | | | | 14. MOTHER'S MAIDEN NAME Anna Skoch | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 289-20-9849 | | 17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma (Metastasis) of Lung 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Carcinomatosis DUE TO (c) Carcinoma of Sigmoid Colon | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1-15 , 19 67 , to 7-23 , 19 67 , that (I) (we) last saw the deceased alive on 7-20 , 19 67 , and that death occurred at 3:45 A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE A. Reitz | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 7-23-67 | |
| 22c. PHYSICIAN'S NAME (Type) A. Reitz M.D. | | | | 22d. ADDRESS Prince Georges Plaza Hyattsville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 26, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City or Town) (County) (State) Cleveland Cuyahoga Ohio | |
| 24. FUNERAL DIRECTOR ADDRESS F. Haeberle-Sons 4739 1321st Ave Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DATE JUL 26 1967 | | 25b. REGISTRAR'S SIGNATURE James J. Jones | |

MEDICAL CERTIFICATION

10027

STATEMENT OF DEATH

Francis George

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10058

CERTIFICATE OF DEATH

10060

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b 10 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Virgie Middle B. Last Ward | | 4. DATE OF DEATH Month July Day 4 Year 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/6/96 |
| 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C. | |
| 11. BIRTHPLACE (County & State, or foreign country) U.S. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Robert Jones | | 14. MOTHER'S MAIDEN NAME Mary E. Davis | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 215-54-7427 | |
| 17. INFORMANT hospital records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION (c) 10 DAYS | | INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from SEP 57 , 19 57 , to 4 JULY , 19 67 , that (I) (we) last saw the deceased alive on 4 JULY , 19 67 , and that death occurred at 10:00 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE C. J. Houmann | | 22b. DATE SIGNED 7. 4. 67 | |
| 22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN | | 22d. ADDRESS RIVERDALE M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7-10-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery | | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia | |
| 24. FUNERAL DIRECTOR John T. Rhines Co | | 25a. REC'D BY REGISTRAR DATE JUL 7 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10059

CERTIFICATE OF DEATH

10061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Glenn Dale) c. LENGTH OF STAY IN 1b 4 yrs. 1 mo. 10 da. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 473 d. STREET ADDRESS 4600 Hillside Road, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Josephine Ware | | | 4. DATE OF DEATH Month Day Year July 29 19 67 | | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 31, 1878 | | 9. AGE (In years last birthday) yrs. 89 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (County & State, or foreign country) Westchester New York | | | |
| 13. FATHER'S NAME William Murry | | | 14. MOTHER'S MAIDEN NAME Julia Gardner | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no - | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Person | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 week unknown unknown | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour "a.m." p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 19, 1963 to July 29 , 19 67 , that (I) (we) last saw the deceased alive on July 29 , 19 67 , and that death occurred at 8:15 P.M. , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Moe Weiss | | 22b. DATE SIGNED July 29, 1967 | | 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | | |
| 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE THEREOF 8-2-1967 | | 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET | | | |
| 23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C. | | | | | | | |
| 24. FUNERAL DIRECTOR W. ERNEST JARVIS Co. | | 25a. REC'D BY REGISTRAR AUG 3 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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Division of Economic

Washington

June 19, 1957

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March 21, 1957

New York

July 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo. Gen. Hosp. | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 4013 - 37th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Norman Middle E. Last Watts | | 4. DATE OF DEATH Month July Day 19 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/7/1909 9. AGE (In years last birthday) 57 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (County & State, or foreign country) Wash., D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Watts | | 14. MOTHER'S MAIDEN NAME Lucy Crounce | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. Mrs. Rena E. Watts (above address) | |
| 17. INFORMANT Mrs. Rena E. Watts (above address) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4201 DUE TO Coronary Vascular Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Generalized Arteriosclerosis (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis | | INTERVAL BETWEEN ONSET AND DEATH IMMED 5 yrs 10 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from 1953 to July , 1967, that (1) (we) last saw the deceased alive on July 19 , 1967, and that death occurred at M , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Benjamin S. Miller | | 22b. DATE SIGNED 19 JULY 1967 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/22/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Com. | | 23d. LOCATION (City, town or county) (State) Colmar Manor, Md. | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | 25a. REC'D BY REGISTRAR W L 24 1967 DATE | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

STATE OF TEXAS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10061

10063

| | | | | | | | |
|---|----------------------------------|---|---|--|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b DOA | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | | d. STREET ADDRESS 6800 Prince George Avenue | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle Edward Last Webster III | | | | 4. DATE OF DEATH Month 7 Day 18 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 25 Aug. 1939 | 9. AGE (In years lost birthday) yrs. 27 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 24 HRS. Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman | | 10b. KIND OF BUSINESS OR INDUSTRY Electronics | | 11. BIRTHPLACE (State or foreign country) Pylesville, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John E. Webster, Jr. | | | | 14. MOTHER'S MAIDEN NAME Eleanor Bartol | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-38-5669 | | 17. INFORMANT Address Mrs. J.E. Webster III, Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) (Pending Microscopic) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Manual |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county) 7-18-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | July 21, 1967 | | St. Mary's | | Pylesville, Md. | |
| 24. FUNERAL DIRECTOR John H. Harkins | | ADDRESS Delta, Penna. | | 25a. REC'D BY REGISTRAR JUL 21 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

3001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 5-63

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|------------------|-------------------|--|--|------------------|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 10062 | | | | | 10064 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | |
| a. COUNTY <i>Prince George</i> MARYLAND | | | | | a. STATE <i>md</i> b. COUNTY <i>md P.G.</i> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | |
| c. LENGTH OF STAY IN lb | | | | | d. STREET ADDRESS | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 12. 197 Bowie Rd | | | | | 12. 197 Bowie Rd | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | |
| First Middle Last | | | | | Month Day Year | | | | |
| <i>MARY R. Williams</i> | | | | | <i>7 - 5 - 1967</i> | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| <i>F</i> | | <i>C</i> | | | | <i>7 - 1904</i> | | <i>62</i> yrs. | |
| | | | | | | | | IF UNDER 1 YEAR | |
| | | | | | | | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | |
| <i>Waitress</i> | | | | | <i>—</i> | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| <i>md</i> | | | | | <i>U.S.A.</i> | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| <i>Louis Williams</i> | | | | | <i>Rachel Hall</i> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | |
| <i>No</i> | | | | | | | | | |
| 17. INFORMANT | | | | | Address | | | | |
| <i>Tarone A. Johnson</i> | | | | | <i>Same as 2D</i> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>uterine C. C.</i> | | | | | | | | | |
| DUE TO | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO | | | | | | | | | |
| DUE TO | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | | 20d. INJURY OCCURRED | | | | |
| Hour a.m. p.m. | | | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | |
| 19 | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | |
| | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>3/18</i> , 19 <i>67</i> , to <i>7/14</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>7/14</i> , 19 <i>67</i> , and that death occurred at <i>3AM</i> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE | | | | | 22b. DATE SIGNED | | | | |
| <i>B. F. Warner</i> M.D. | | | | | <i>7/10/67</i> | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | |
| | | | | | <i>Laurel md</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town or county) (State) | |
| <i>7-8-67</i> | | | <i>7-8-67</i> | | <i>Bacountown Ch. Cemetery</i> | | | <i>Laurel md</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | | | | 25a. REC'D BY REGISTRAR | | | | |
| <i>H.S. Washington</i> | | | | | <i>4925 Klame One NE</i> | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| | | | | | <i>J. Charles Judge</i> | | | | |

33001

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10063

10065

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u> | |
| c. LENGTH OF STAY IN 1b. <u>DOA</u> | | d. STREET ADDRESS <u>P.O. Box 6</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>VERNON AUBREY WRAY JR</u> | | 4. DATE OF DEATH <u>July 9 1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-17-1951</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Portsmouth Va</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>VERNON Aubrey Wray Sr</u> | | 14. MOTHER'S MAIDEN NAME <u>Eubyn Bickes</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>Box 6 Accokeek Md</u> | |
| 17. INFORMANT <u>Brandy</u> Address <u>Boston</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>few minutes</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in water while fishing and drank</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Accokeek</u> (County) <u>Pr Geo</u> (State) <u>Md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-10-67 | |
| EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 3318 Annapolis Rd | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bladensburg Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>7-12-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>CHRIST CH. Cem.</u> | 23d. LOCATION (City or Town) <u>Accokeek, P.G., MD.</u> (County) (State) |
| 24. FUNERAL DIRECTOR <u>HUNT FUNERAL HOME, WALDORF, MD</u> | | 25a. REC'D BY REGISTRAR <u>JUL 13 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

62001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

90

MEDICAL CERTIFICATION

VR A15 (4)
20 M 1/66

10064

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10066

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | c. LENGTH OF STAY IN 1b <u>7 YEARS</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Manor</u> | | d. STREET ADDRESS <u>2900 Connecticut Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>A.</u> Last <u>Wright</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>OCT. 17, 1885</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LIBRARIAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>US GOVERNMENT</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> |
| 13. FATHER'S NAME <u>J. Eliot Wright</u> | | 14. MOTHER'S MAIDEN NAME <u>Susan Watson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>Sister Mark</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis - Arterio</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , to <u>July 30, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 30, 1967</u> , and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Thomas E. McMahon</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>7-30-67</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>T.E. McMahon M.D.</u> | | 22d. ADDRESS <u>3000 - Conn. Ave. N.W. Wash. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8-2-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u> |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> | | 25a. REC'D BY REGISTRAR <u>DATE AUG 2 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

10003

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

1900-1901

1900-1901

1900-1901

1900-1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | | | | | | | |
|---|------------------|--|---|--|--|---|------------------|---|--|--|---|--|------|---|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u> c. LENGTH OF STAY IN 1b <u>16-1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PRINCE GEORGES GEN. HOSP</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GREENBELT</u> d. STREET ADDRESS <u>7016 HANOVER PARKWAY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>ESTHER ANN YOUNG</u> | | | 4. DATE OF DEATH Month <u>JULY</u> Day <u>30</u> Year <u>1967</u> | | | 5. SEX <u>FEMALE</u> | | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | | |
| 8. DATE OF BIRTH <u>NOV 20, 1994</u> | | | 9. AGE (In years last birthday) <u>72</u> yrs. <table border="1"> <tr> <th>IF UNDER 1 YEAR</th> <th>IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table> | | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Months | Days | | Hours | | Min. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | | 11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u> | | |
| IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | | | |
| Months | Days | | | | | | | | | | | | | | | | | | | | | |
| | Hours | | | | | | | | | | | | | | | | | | | | | |
| | Min. | | | | | | | | | | | | | | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>Unknown Schubert</u> | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | | | | | | | | | | |
| 16. SOCIAL SECURITY NO. <u>205181886</u> | | | 17. INFORMANT <u>KENNETH M. YOUNG - 7016 HANOVER PKWY GREENBELT MD</u> | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Infarct, Acute</u> (b) <u>Posterior Coronary Occlusion</u> (c) <u>Arteriosclerotic Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from <u>14 July 1967</u> , to <u>14 July 1967</u> , that (I) (we) last saw the deceased alive on <u>14 July 1967</u> , and that death occurred at <u>7AM</u> , from the causes and on the date stated above. | | | | | | | | | | | | |
| 22a. SIGNATURE <u>James B. Moffett</u> | | | | 22b. DATE SIGNED <u>7-30-67</u> | | | | 22c. PHYSICIAN'S NAME (Type) <u>James B. Moffett</u> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>AUG 3, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>CROWN CREST MEM CEM.</u> | | 23d. LOCATION (City, town or county) (State) <u>HYDE CITY, PENNA.</u> | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co - RIVERDALE, MD.</u> | | | | 25a. REC'D BY REGISTRAR <u>AUG 4 1967</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | | | | |

10002

Nov